CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17B:27A-2 et seq.

Source and Effective Date

Adopted Concurrent Proposal, R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993.
See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Executive Order No. 66(1978) Expiration Date

Chapter 20, Individual Health Coverage Program, expires August 13, 1998.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993, set to expire August 13, 1993. See: 25 N.J.R. 2945(a). Chapter 20 was readopted by R.1993 d.439. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

11:20–1.1 Purpose and scope

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

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

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).
Petition for Rulemaking: Exhibits A through F.
See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).

11:20–1.2 Definitions

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

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A–2 through 16).

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

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

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in New Jersey. Carriers that are affiliated carriers shall be treated as one carrier.

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

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

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

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

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

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth as Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by Indemnity or PPO and POS delivery systems for Plans A–E, and if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. Number of contracts in force geographically, categorized by the first three digits of the zip code, as of December 31 of the previous year;

2. Number of lives insured, separated by sex and age distribution as of December 31 of the previous year beginning with 12/31/94; and

3. Number of contracts by salary categories as reported by the subscriber on the household income section of the application.

11:20–17.5 Penalties

Failure to provide the enrollment status reports within the time and in the format required by this subchapter shall result in the imposition of penalties as may be provided by law.

APPENDIX

EXHIBIT A

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

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

[CARRIER]

BASIC HEALTH BENEFITS PLAN

(New Jersey BASIC Health Benefits Plan)

Policy Term. The Policy takes effect on [__________], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey BASIC Health Benefits Plan.

[Dividends are apportioned each year.]

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page [22].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

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

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Policy. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

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

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

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

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. 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 Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;

(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;

(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and

(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while you are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:

(1) Spouse;

(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school. (We can ask for periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:

(1) the Child remains unmarried and unable to be self-supportive;

(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the child's support and maintenance. You have 31 days form the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

Except as allowed under the Primary Care Services provision of the CHARGES COVERED WITH SPECIAL LIMITATIONS section, diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your particular condition, as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

   —The American Medical Association Drug Evaluations;

   —The American Hospital Formulary Service Drug Information; or

   —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.

FACILITY. A place We are required by law to recognize which:

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;
(b) accredited for its stated purpose by the Joint Commission; or
(c) licensed, certified, or accredited by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission;
(b) approved as a Hospital by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

[**IN-NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

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

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

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, serious burns, bone fractures, wound requiring sutures, poisoning and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife 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 Policy.

[**OUT-OF-NETWORK PROVIDER.** A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Covered Person; and
(b) with or without interruption of coverage.

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

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

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

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescription drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

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

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

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

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

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or,

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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 or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

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

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

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified or accredited by the state in which it operates.

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

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, 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 task 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 of the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for only one person.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Policy for You and Your Spouse.

[(e) **CHILD(REN) COVERAGE**—coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(b) **SPOUSE**—Your Spouse, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(c) **CHILD**—Your Child, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below and who qualifies as a Dependent, as defined in this Policy.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provision of that plan. We may require proof that the other Coverage has been terminated.

(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM, UNLESS OTHERWISE STATED.

FACILITY BENEFIT—30 days Inpatient Hospital care.

FACILITY COINSURANCE—20%

COINSURANCE CAP—$5000/Covered Person; no benefit after 30 days.

PRACTITIONER'S SERVICES COINSURANCE—50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

NOTE: The Coinsurance Amounts cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Copayments

HOSPITAL INPATIENT COPAYMENT

per Covered Person per day	$250
maximum Copayment per Covered Person per Period of Confinement	$1250
maximum Copayment per Covered Person per Benefit Period	$2500

CASH DEDUCTIBLE

for Hospital Confinement	None (Note: See Hospital Inpatient Copayment)
for Primary Care Services	None
for immunizations and lead screening for children	None
for all other Covered Charges	
per Covered Person	$250
per Covered Family	$500

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Primary Care Services are not subject to Deductibles and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates][:

For Single Coverage	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

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

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is charged:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

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

V. BENEFIT DEDUCTIBLES, COPAYMENT AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for these charges. The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once the Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We Pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the Individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Hospital Inpatient Copayment: Each time You are confined in a Hospital or Rehabilitation Center, which Rehabilitation Center confinement is not immediately preceded by an Inpatient Hospital stay, You must pay a $250.00 Hospital Inpatient Copayment for each day of confinement, up to a maximum of $1250 per Covered Person for Period of Confinement, up to a maximum $2500 Hospital Inpatient Copayment per Covered Person per Benefit Period.

Coinsurance Cap: This Policy limits the Facility Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Facility benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

NOTE: There is no Coinsurance credit from previous coverage.

Hospital Inpatient Copayment Carryover: There will be no carryover of Deductibles or Coinsurance into the next Benefit Period. However, a Covered Person will receive credit for any Hospital Inpatient Copayment satisfied during a Period of Confinement immediately preceding or continuing into a new Benefit Period, provided, if this Policy is replacing previous coverage, that there has been no lapse in coverage between the previous coverage and this Policy.

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

VI. COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE "UTILIZATION REVIEW" SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

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

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

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two home health care days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
   - ordered by Your Practitioner;

- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility;

(b) the services and supplies must be: (a) ordered by Your 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. 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;

(c) the home health care plan must be set up in writing by your Practitioner within 14 days after home health care starts;

(d) 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.

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.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Practitioner has certified in writing that Your 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 for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. 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 Your Practitioner;

(c) included in the Hospice care program; and

(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;

(b) funeral services and arrangements;

(c) legal or financial counseling or services;

(d) treatment not included in the Hospice care plan; or

(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic.

We cover emergency room treatment only if such treatment subsequently results in Your admission to a Hospital.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a Cesarean Section delivery. These covered charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to either the attending Practitioner determining that in-patient care is medically necessary or the mother requesting the in-patient care.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 are not Pre-approved by Us are Non-Covered Charges.

Practitioner Charges for Nonsurgical Care and Treatment: We only cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for surgery including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover charges for cosmetic surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We cover reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts and the costs of prostheses following a mastectomy on one breast or both breasts.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Chemotherapy, Radiation Therapy and Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the "Utilization Review" section of this Policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

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

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Rehabilitation Center: Subject to our advance written approval, when rehabilitation care can take the place of Inpatient care in a Hospital, We cover such care furnished to You in a Rehabilitation Center on the basis of two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished. We will pay for two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished, per Benefit Period. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second (or third) opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month Preexisting Condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Policy measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Primary Care Services: We will cover up to $100 per Covered Person per Benefit Period, up to a maximum of $300 per family per Benefit Period, for routine physical examinations. Diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Primary Care Services. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

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 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 Department of Health. These charges are not subject to the Deductible.

Therapy Services: We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But We do not cover Dialysis Treatment.

[**Transplants:** We cover Medically Necessary and Appropriate services and supplies for:

**[(a) Analogous 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.

(b) 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.]

NOTE TO CARRIERS: P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (a) and (b) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case there will be no change).

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

VIII. UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. **IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF *WE ASK YOU TO OBTAIN* A SECOND AND/OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, *AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S), OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION,* WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.**

B. **IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND *NEITHER OF* THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.**

C. **NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.**

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless we determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1–Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and Appropriate, we will make payment as otherwise provided in this policy.

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy

Arthroscopy

Bunionectomy

Carpal Tunnel Surgery

Cesarean Section

Cholecystectomy

Coronary Artery Angioplasty

Coronary Artery Bypass Graft

Esophagoscopy

Excision of Intervertebral Disk

Gastroduodenoscopy

Hip Replacement

Hysterectomy

Knee Replacement

Lower Back Surgery

Mastectomy

Meniscectomy

Myringotomy

Pacemaker Implantation

Prostatectomy

Rhinoplasty

Septectomy with Rhinoplasty

Tonsillectomy

Tubal Transection and/or Ligation

Tympanoplasty

Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization

CAT SCAN

Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care

Skilled Nursing Care

Maternity Care (See STEP 2(a))

Hospice Care

Infusion Therapy

STEP 2–Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care,** You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Practitioner must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, **or the next business day, whichever is later,** as well as put in writing to You, what specific information is needed to make that Determination. **In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.**

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We *subsequently* Determine that the hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this policy.

STEP 3–Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PERFORMANCE OF THE PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4–Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF *NEITHER* THE SECOND *NOR* THIRD OPINIONS CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY *50%* PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [Carrier].

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"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. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The 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:
 - Us
 - attending Practitioner
 - Covered Person
 - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person 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 the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We Determine to be Experimental or Investigational.

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of the Policy. [However, the requirements of the "Utilization Review" section will not apply.]]

X. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

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

Alcoholism.

Ambulance—air, water, ground and rail.

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

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

Custodial care or domiciliary care.

Dental care or treatment, including appliances.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

Dialysis treatment.

Durable Medical Equipment.

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

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

Extraction of teeth, including bony impacted teeth.

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

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

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

Herbal medicine.

Hypnotism.

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

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

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

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

Mental or Nervous Conditions.

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Primary Care Services.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services except as otherwise stated in this Policy.

Outpatient Prescription Drugs.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
—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;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;

—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate except as otherwise stated in this Policy; or
—which You are not legally obligated to pay.

Special medical reports not directly related to Your treatment (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, and non-human organ transplants [except as otherwise stated in this Policy].

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

XI. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a. name(s) and address(es) of patient and Policyholder;
b. Policyholder's [identification] number;
c. date of service;
d. claim number;
e. Provider's name; and
f. why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

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

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

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

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XII. [XIII.] RIGHT TO RECOVERY— THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy 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 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 paid benefits and these amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15–97.

The repayment will be equal to the amount of benefits paid 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.

We shall require the return of health benefits paid 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.

The repayment agreement shall 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 Policy 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or Federal law and that other law precludes repayment.

XIII. [XIV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or that of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

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

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

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

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY-RENEWAL PRIVILEGE

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

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

(a) nonpayment of Premiums (coverage will end as of the end of the grace period);
(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);
(d) You become eligible either for Medicare or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);
(e) You become covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the new Individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan);
(f) non-renewal as authorized by the Board (coverage will end on the date determined by the Board).

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

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

CONTINUING RIGHTS

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

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

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

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

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

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

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

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

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[IN-NETWORK AND OUT-OF-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

An In-Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by An Out-of-Network Provider may be different than our In-Network Provider Allowance; also, a Out-of-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

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

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this policy as of each Anniversary Date, if this Policy stays in force by the payment of premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program as the standard policy form for the individual health benefits Plan B.

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

[CARRIER]

INDIVIDUAL HEALTH BENEFITS PLAN B

(New Jersey Individual Health Benefits Plan B)

Policy Term. The Policy takes effect on [__________], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

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

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan B.

[Dividends are apportioned each year.]

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [22].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

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

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Policy. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws; or

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

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

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

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

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

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

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;

(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;

(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and

(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:

(1) Spouse;

(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school. (We can ask for periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:

(1) the Child remains unmarried and unable to be self-supportive;

(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

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

Except as allowed under the Primary Care Services provision of the CHARGES COVERED WITH SPECIAL LIMITATIONS section, diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your particular condition as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

—The American Medical Association Drug Evaluations;

—The American Hospital Formulary Service Drug Information; or

—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.

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

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;

(b) accredited for its stated purpose by the Joint Commission; or

(c) licensed, certified, or accredited by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission;

(b) approved as a Hospital by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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 for Substance Abusers is not a Hospital.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to an Out-of-Network Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

[**IN-NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

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

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

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife 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 Policy.

[**OUT-OF-NETWORK PROVIDER.** A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Covered Person; and

(b) with or without interruption of coverage.

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

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

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

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescription drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

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

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

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

PRIMARY RESIDENCE. The location where You reside for the majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;

(c) Reasonable and Customary pre-operative and post-operative care; or

(d) Any of the procedures designated by C.P.T. codes as surgery.

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

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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

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

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for only one person.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Policy for You and Your Spouse.

[(e) **CHILD(REN) COVERAGE**—coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(b) **SPOUSE**—Your Spouse, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(c) **CHILD**—Your Child, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below and who qualifies as a Dependent, as defined in this Policy.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other Coverage has been terminated.

(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—40%.

OTHER COVERED CHARGES—40%.

COINSURANCE CAP—After $3,000/Covered Person, $6,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE

for Primary Care Services	None
for immunizations and lead screening for children	None
for all other Covered Charges	
per Covered Person	[$250, $500, $1,000]
per Covered Family	[$500, $1000, $2000]

HOSPITAL INPATIENT COPAYMENT

per Covered Person per day	$200
maximum Copayment per Covered Person per Period of Confinement	$1000
maximum Copayment per Covered Person per Benefit Period	$2000

Note: The Hospital Inpatient Copayment is in addition to the Cash Deductible.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—365 days, if preapproved.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000 Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to cash deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES

Physical Therapy	30 Visits per Covered Person per Benefit Period
Occupational Therapy	30 Visits per Covered Person per Benefit Period
Speech Therapy	30 Visits per Covered Person per Benefit Period

Cognitive Rehabilitation Therapy	30 Visits per Covered Person per Benefit Period Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our Pre-Approval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage .... [$]
For Adult and Child(ren) Coverage .... [$]
For Family Coverage .... [$]
For Husband and Wife Coverage .... [$]
[For Child(ren) Coverage .... $]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

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

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

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

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

V. BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We Pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the Individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Hospital Inpatient Copayment: Each time You are confined in a Hospital or Rehabilitation Center, which Rehabilitation Center confinement is not immediately preceded by an Inpatient Hospital stay, You must pay a $200 Hospital Inpatient Copayment for each day of confinement, up to a maximum of $1000 per Covered Person for Period of confinement, up to a maximum $2000 Hospital Inpatient Copayment per Covered Person per Benefit Period. **NOTE:** This Hospital Inpatient Copayment is in addition to the Cash Deductible.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

NOTE: There is no Coinsurance credit from previous coverage.

Hospital Inpatient Copayment Carryover: A Covered Person will receive credit for any Hospital Inpatient Copayment satisfied during a Period of Confinement immediately preceding and continuing into a new Benefit Period provided, if this Policy is replacing previous coverage, that there has been no lapse in coverage between the previous coverage and this Policy. Except as stated above, there is no carryover of a Copayment from one Benefit Period into a succeeding Benefit Period. **Note:** There is never a carryover of Deductible or Coinsurance from one Benefit Period into a succeeding Benefit Period.

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

VI. COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

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

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

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily Room and Board Limits

During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
  1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
  2. The services and supplies must be:
     - ordered by Your Practitioner;
     - included in the home health care plan; and
     - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

(b) The services and supplies must be: (a) ordered by Your 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. 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.

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

(d) 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.

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.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other copayments and coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a Cesarean Section delivery. These covered charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to either the attending Practitioner determining that in-patient care is medically necessary or the mother requesting the in-patient care.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 are not Pre-approved by Us are Non-Covered Charges.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an Accident). All services are

covered only if You comply with the Utilization Review section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover cosmetic surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We 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.

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

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

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are insured 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.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage, measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month Pre-Existing Condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Policy measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Primary Care Services. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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 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 Department of Health. These charges are not subject to the Deductible.

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 Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period per Covered Person for each of the following Therapy Services: Physical Therapy, Occupational Therapy, Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ):

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

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogenic Bone Marrow
**[(j) Autologous Bone Marrow and Dose-Intensive Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Expenses.]

**[(j) Autologous Bone Marrow Transplant and associated dose-intensive chemotherapy but only if performed by institutions approved by the National Cancer Institute guidelines of the American Society of Clinical Oncologists.
(k) Peripheral blood stem cell transplants but only if performed by institutions approved by this National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

****NOTE TO CARRIERS:** P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (j) and (k) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case You must use the above option which includes (j) only).

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

VIII. UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, A SECOND AND/OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, *AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S), OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION,* WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND *NEITHER OF* THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless we determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1–Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We Subsequently Determine the in-patient admission to have been Medically Necessary and Appropriate, we will make payment as otherwise provided in this policy.

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy

Arthroscopy

Bunionectomy

Carpal Tunnel Surgery

Cesarean Section

Cholecystectomy

Coronary Artery Angioplasty

Coronary Artery Bypass Graft

Esophagoscopy

Excision of Intervertebral Disk

Gastroduodenoscopy

Hip Replacement

Hysterectomy

Knee Replacement

Lower Back Surgery

Mastectomy

Meniscectomy

Myringotomy

Pacemaker Implantation

Prostatectomy

Rhinoplasty

Septectomy with Rhinoplasty

Tonsillectomy

Tubal Transection and/or Ligation

Tympanoplasty

Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization

CAT SCAN

Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care

Skilled Nursing Care

Maternity Care (See STEP 2(a))

Hospice Care

Infusion Therapy

STEP 2–Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care,** You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, **or the next business day, whichever is later,** as well as put in writing to You, what specific information is needed to make that Determination. **In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.**

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We *subsequently* Determine that the hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this policy.

STEP 3–Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may require that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PERFORMANCE OF THE PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4–Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF *NEITHER* THE SECOND *NOR* THIRD OPINIONS CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY *50%* PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"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 Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The 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:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person 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 the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We Determine to be Experimental or Investigational.

X. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

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

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

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

Custodial care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

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

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

Extraction of teeth except as otherwise specifically covered.

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

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

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

Herbal medicine.

Hypnotism.

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

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

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

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

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Primary Care Services.

Non-Prescription Drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Nutritional counseling and related services except as otherwise stated in this Policy.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless you have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:
—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
—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;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate except as otherwise stated in this Policy; or
—which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

XI. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof,

including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a. name(s) and address(es) of patient and Policyholder;
b. Policyholder's [identification] number;
c. date of service;
d. claim number;
e. Provider's name; and
f. why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

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

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

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

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XII. [XIII.] RIGHT TO RECOVERY— THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy 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 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 paid benefits and these amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15–97.

The repayment will be equal to the amount of benefits paid 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.

We shall require the return of health benefits paid 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.

The repayment agreement shall 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 Policy 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.]

XIII. [XIV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;

(b) the Policyholder's application, a copy of which is attached to the Policy;

(c) any riders, endorsements or amendments to the Policy; and

(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

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

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

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

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

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

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

(a) nonpayment of Premiums (coverage will end as of the end of the grace period);
(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);
(d) You become eligible either for Medicare|, MedicaidŒ or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);
(e) You become covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the new Individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan);
(f) non-renewal as authorized by the Board (coverage will end on the date determined by the Board).

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

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

CONTINUING RIGHTS

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

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

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

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

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

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

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

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

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[IN-NETWORK AND OUT-OF-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

An In-Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out-of-Network Provider may be different than our In-Network Provider Allowance; also, an Out-of-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

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

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this policy as of each Anniversary Date, if this Policy stays in force by the payment of premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

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

[CARRIER]

BASIC HEALTH BENEFITS PLAN C

(New Jersey Individual Health Benefits Plan C)

Policy Term. The Policy takes effect on [__________], the Policy Effective Date. The term of this Policy starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

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

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan C.

[NOTICE: THE CASH DEDUCTIBLE AND OUT OF POCKET PROVISIONS CONTAINED IN THIS POLICY ARE INTENDED TO PRODUCE A PLAN THAT COULD QUALIFY AS A MEDICAL SAVINGS ACCOUNT (MSA) PLAN UNDER FEDERAL LAW. HOWEVER, ACTUAL QUALIFICATION OF A PARTICULAR PLAN WILL BE SUBJECT TO FEDERAL REGULATIONS.]

[Dividends are apportioned each year.]

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page [22].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

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

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Policy.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

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

A Facility is not a Birthing Center if it is part of a Hospital.

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

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

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

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

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

COVERED CHARGE. 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 Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while you are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:

(1) Spouse;

(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school. (We can ask for periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:

(1) the Child remains unmarried and unable to be self-supportive;

(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

Except as allowed under the Primary Care Services provision of the CHARGES COVERED WITH SPECIAL LIMITATIONS section, diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily for a medical purpose;

(c) mainly and customarily used to serve a medical purpose;

(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 hospitalization 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 Your 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 Your particular condition, as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

   —The American Medical Association Drug Evaluations;

   —The American Hospital Formulary Service Drug Information; or

   —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.

FACILITY. A place We are required by law to recognize which:

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;
(b) accredited for its stated purpose by the Joint Commission; or
(c) licensed, certified, or accredited by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission;
(b) approved as a Hospital by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

[**IN-NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

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

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

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, serious burns, bone fractures, wound requiring sutures, poisoning and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will

recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

[**OUT-OF-NETWORK PROVIDER.** A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Covered Person; and

(b) with or without interruption of coverage.

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

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

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

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescription drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

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

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

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

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

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

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

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

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, 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 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 task 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 of the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for only one person.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Policy for You and Your Spouse.

[(e) **CHILD(REN) COVERAGE**—coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(b) **SPOUSE**—Your Spouse, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(c) **CHILD**—Your Child, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below and who qualifies as a Dependent, as defined in this Policy.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provision of that plan. We may require proof that the other Coverage has been terminated.

(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM, UNLESS OTHERWISE STATED.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—30%

OTHER COVERED CHARGES—30%

COINSURANCE CAP—After $2,500/Covered Person, $5,000/ family. We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE

for Primary Care Services	None
for immunizations and lead screening for children	None
for all other Covered Charges	
per Covered Person	[$250, $500, $1000 or $2,500]
per Covered Family	[$500, $1,000, $2,000 or $5,000]

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to cash deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES

Physical Therapy	30 Visits per Covered Person per Benefit Period
Occupational Therapy	30 Visits per Covered Person per Benefit Period
Speech Therapy	30 Visits per Covered Person per Benefit Period
Cognitive Rehabilitation Therapy	30 Visits per Covered Person per Benefit Period
	Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our Pre-Approval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

[**Note to Carriers:** This following alternate option for Section III, Schedule of Benefits should be used only if the policy is intended to produce a plan that could qualify as a Medical Savings Account (MSA) plan.]

[III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE	30%
OTHER COVERED CHARGES	30%
CASH DEDUCTIBLE	
[Per Covered Person]	[$1,500][$2,250]
[Per Covered Family]	[$3,000][$4,500]
OUT OF POCKET MAXIMUM	
[Per Covered Person	$3,000]
[Per Covered Family	$5,500]

NOTE: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS	Subject to cash deductible and coinsurance.
PRIMARY CARE SERVICES	$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductibles or Coinsurance.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premiums is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the 45th day following the date of the

conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Policy.

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

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below. The Deductibles are shown in the "Schedule of Benefits" section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We Pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the Individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

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

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

[Note to Carriers: This following alternate option for Section V, Benefit Deductibles and Coinsurance should be used only if the policy is intended to produce a plan that could qualify as a Medical Savings Account (MSA) plan.]

[V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductible is shown in the "Schedule of Benefits" section in this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Benefit Period. Once any combination of persons in a family meets the Per Covered Family Cash Deductible shown in the "Schedule of Benefits" section of this Policy, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance, for the rest of that Benefit period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Out of Pocket Maximum: The Out of Pocket Maximums "Per Covered Person" and "Per Covered Family" are shown in the "Schedule of Benefits" section of this Policy. The Out of Pocket Maximums may only be satisfied with Covered Charges. In the case of single coverage, for a Covered Person, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Person must pay during each Benefit Period. Once the Per Covered Person Out of Pocket Maximum has been met during a Benefit Period, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Benefit Period. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family must pay during each Benefit Period. Once the Per Covered Family Out of Pocket Maximum has been met during a Benefit Period, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

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

VI. COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

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

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

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the section of the Policy called "Exclusions."

Daily Room and Board Limits During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room

and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
   - ordered by Your Practitioner;
   - included in the home health care plan; and
   - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
(b) The services and supplies must be: (a) ordered by Your 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. 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.
(c) The home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your Practitioner at least once every 60 days.
(d) 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.

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.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and

(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. **This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.**

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These covered charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to either the attending Practitioner determining that in-patient care is medically necessary or the mother requesting the in-patient care.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 are not Pre-approved by Us are Non-Covered Charges.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy and Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the "Utilization Review" section of this Policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We cover reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy of one breast or both breasts.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

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

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including, but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioners prescription.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests

when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are insured 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.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any Practitioner.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefits.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month Pre-Existing Condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Policy measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Primary Care Services. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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 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 Department of Health.

These charges are not subject to the Deductible.

Private Duty Nursing Care: [Carrier] 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 Non-Covered Expense.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, we only cover 30 visits per Benefit Period per Covered Person for each of the following Therapy Services: Physical Therapy, Occupational Therapy, Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

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

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogenic Bone Marrow
**[(j) Autologous Bone Marrow and Dose-Intensive Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Expenses.]

**[(j) 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.
(k) 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.]

****NOTE TO CARRIERS:** P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (j) and (k) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case you must use the above option which includes (j) only).

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. **IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, *WE ASK YOU TO OBTAIN* A SECOND AND/OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, *AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S), OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION,* WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.**

B. **IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND *NEITHER OF* THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.**

C. **NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.**

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1—Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We Subsequently Determine the in-patient admission to have been Medically Necessary and Appropriate, we will make payment as otherwise provided in this policy.

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy

Arthroscopy

Bunionectomy

Carpal Tunnel Surgery

Cesarean Section

Cholecystectomy

Coronary Artery Angioplasty

Coronary Artery Bypass Graft

Esophagoscopy

Excision of Intervertebral Disk

Gastroduodenoscopy

Hip Replacement

Hysterectomy

Knee Replacement

Lower Back Surgery

Mastectomy

Meniscectomy

Myringotomy

Pacemaker Implantation

Prostatectomy

Rhinoplasty

Septectomy with Rhinoplasty

Tonsillectomy

Tubal Transection and/or Ligation

Tympanoplasty

Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization

CAT SCAN

Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care

Skilled Nursing Care

Maternity Care (See STEP 2(a))

Hospice Care

Infusion Therapy

STEP 2—Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care,** You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, **or the next business day, whichever is later,** as well as put in writing to You, what specific information is needed to make that Determination. **In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.**

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this policy.

STEP 3—Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may require that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PERFORMANCE OF THE PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50%. PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF *NEITHER* THE SECOND *NOR* THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY *50%* PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury or in completing a course of care outside of the acute hospital setting, for example, completing a course of IV antibiotics at home.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"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 Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The 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:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person 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 the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determine to be Experimental or Investigational.

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the

Policy. However, the requirements of the "Utilization Review" section will not apply.]]

X. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

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

Ambulance, in the case of non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

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

Custodial Care or domiciliary care.

Dental care or treatment, (including appliances) except as otherwise specifically Covered.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

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

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

Extraction of teeth except as otherwise specifically covered.

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

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

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

Herbal medicine.

Hypnotism.

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

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

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

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

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Primary Care Services.

Non-Prescription Drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:
—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for these services;
—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;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country under the terms stated in the definition of Dependent;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate except as otherwise stated in this Policy; or
—which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vitamins and dietary supplements.

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 used to eliminate baldness.

XI. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents;

(e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

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

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

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

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XII. [XIII.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy 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 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 paid benefits and these amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15–97.

The repayment will be equal to the amount of benefits paid 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.

We shall require the return of health benefits paid 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.

The repayment agreement shall 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 Policy 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or Federal law and that other law precludes such repayment.]

XIII. [XIV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;

(b) the Policyholder's application, a copy of which is attached to the Policy;

(c) any riders, endorsements or amendments to the Policy; and

(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

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

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

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

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

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

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

(a) nonpayment of Premiums (coverage will end as of the end of the grace period);

(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);
(d) You become eligible either for Medicare, or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);
(e) You become covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the new Individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan);
(f) non-renewal as authorized by the Board (coverage will end on the date determined by the Board).

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

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

CONTINUING RIGHTS

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

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

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

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

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

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

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

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

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[IN-NETWORK AND OUT-OF-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

An In-Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out-of-Network Provider may be different than our In-Network Provide Allowance; also, an Out-of-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

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

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this policy as of each Anniversary Date, if this Policy stays in force by the payment of premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other Federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit C.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate option for sections III and V.

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

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

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN D
(New Jersey Individual Health Benefits Plan D)

Policy Term. The Policy takes effect on [__________], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

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

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan D.

[NOTICE: THE CASH DEDUCTIBLE AND OUT OF POCKET PROVISIONS CONTAINED IN THIS POLICY ARE INTENDED TO PRODUCE A PLAN THAT COULD QUALIFY AS A MEDICAL SAVINGS ACCOUNT (MSA) PLAN UNDER FEDERAL LAW. HOWEVER, ACTUAL QUALIFICATION OF A PARTICULAR PLAN WILL BE SUBJECT TO FEDERAL REGULATIONS.]

[Dividends are apportioned each year.]

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page [23].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary Charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

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

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Policy. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

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

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

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

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

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

COVERED CHARGE. 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 Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;

(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;

(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and

(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:

(1) Spouse;

(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:

(1) the Child remains unmarried and unable to be self-supportive;

(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

Except as allowed under the Primary Care Services provision of the CHARGES COVERED WITH SPECIAL LIMITATIONS section, diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily for a medical purpose;

(c) mainly and customarily used to serve a medical purpose;

(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 hospitalization 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 Your 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 Your particular condition, as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

   —The American Medical Association Drug Evaluations;

   —The American Hospital Formulary Service Drug Information; or

   —The United States Pharmacopeia Drug Information.

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

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

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;

(b) accredited for its stated purpose by the Joint Commission; or

(c) licensed, certified, or accredited by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission;
(b) approved as a Hospital by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

[**IN-NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

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

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

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

[**OUT-OF-NETWORK PROVIDER.** A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Covered Person; and

(b) with or without interruption of coverage.

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

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

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

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

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

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

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

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

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

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

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

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, 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 of the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for only one person.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Policy for You and Your Spouse.
[(e) **CHILD(REN) COVERAGE**—coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for Medicare, or a Group Health Benefits Plan except as provided below.
(b) **SPOUSE**—Your Spouse, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.
(c) **CHILD**—Your Child, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below, and who qualifies as a Dependent, as defined in this Policy.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other Coverage has been terminated.

(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM UNLESS OTHERWISE STATED.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—20%.

COINSURANCE CAP—After $2,000/Covered Person, $4,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE

for Primary Care Services	None
for immunizations and lead screening for children	None
for all other Covered Charges	
per Covered Person	[$250, $500, $1000]
per Covered Family	[$500, $1000, $2000]

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to cash deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES

Physical Therapy	30 Visits per Covered Person per Benefit Period
Occupational Therapy	30 Visits per Covered Person per Benefit Period
Speech Therapy	30 Visits per Covered Person per Benefit Period
Cognitive Rehabilitation Therapy	30 Visits per Covered Person per Benefit Period
	Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our Pre-Approval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

[**Note to Carriers:** This following alternate option for Section III, Schedule of Benefits should be used only if the policy is intended to produce a plan that could qualify as a Medical Savings Account (MSA) plan.]

[III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE	25%
OTHER COVERED CHARGES	20%
CASH DEDUCTIBLE	
[Per Covered Person]	[$1,500][$2,250]
[Per Covered Family]	[$3,000][$4,500]
OUT OF POCKET MAXIMUM	
[Per Covered Person	$3,000]
[Per Covered Family	$5,500]

NOTE: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS	Subject to cash deductible and coinsurance.
PRIMARY CARE SERVICES	$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductibles or Coinsurance.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay [Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. 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.]

REINSTATEMENT

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

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

  (1) by amendment of the Policy; or

  (2) by reason of any provision of law or any government program or regulation;

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

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

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for these charges (subject to the Family Deductible Cap as described below). The Deductibles are shown in the "Schedule of Benefits" section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while

insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We Pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the Individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

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

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

[**Note to Carriers:** This following alternate option for Section V, Benefit Deductibles and Coinsurance should be used only if the policy is intended to produce a plan that could qualify as a Medical Savings Account (MSA) plan.]

[V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductibles before We pay any benefits to You for those charges. The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Benefit Period. Once any combination of persons in a family meets the Per Covered Family Cash Deductible shown in the "Schedule of Benefits" section of this Policy, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Benefit period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Out of Pocket Maximum: The Out of Pocket Maximums "Per Covered Person" and "Per Covered Family" are shown in the "Schedule of Benefits" section of this Policy. The Out of Pocket Maximums may only be satisfied with Covered Charges. In the case of single coverage, for a Covered Person, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Person must pay during each Benefit Period. Once the Per Covered Person Out of Pocket Maximum has been met during a Benefit Period, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Benefit Period. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family must pay during each Benefit Period. Once the Per Covered Family Out of Pocket Maximum has been met during a Benefit Period, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

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

VI. COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

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

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

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

Blood: We cover blood, blood products and blood transfusions except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits

During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services for the Special Care Unit.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;

(e) home health aide services;

(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and

(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
   - ordered by Your Practitioner;
   - included in the home health care plan; and
   - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

(b) The services and supplies must be: (a) ordered by Your 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. 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.

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

(d) 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.

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.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;

(b) ordered by Your Practitioner;

(c) included in the Hospice care program; and

(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;

(b) funeral services and arrangements;

(c) legal or financial counseling or services;

(d) treatment not included in the Hospice care plan; or

(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other copayments, and coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These covered charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to either the attending Practitioner determining that in-patient care is medically necessary or the mother requesting the in-patient care.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 are not Pre-approved by Us are Non-Covered Charges.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the "Utilization Review" section of this Policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We 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.

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

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

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs, including contraceptives which require a Practitioner's prescription.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay covered charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are insured 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.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or properly licensed or certified Practitioner.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Impatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month Pre-Existing Condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Policy, measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Primary Care Services. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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 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 Department of Health.

These charges are not subject to the Deductible.

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 Care Charges"** section. Any other charges for private duty nursing care are Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your 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.

Therapy Services: We cover the Therapy Services listed in the **"Definitions"** section of this Policy. However, We only cover 30 visits per Benefit Period per Covered Person for each of the following Therapy Services: Physical Therapy, Occupational Therapy, Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ): We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogenic Bone Marrow
**[(j) Autologous Bone Marrow and Dose-Intensive Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Expenses.]

**[(j) 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.
(k) 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.]

**NOTE TO CARRIERS: P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (j) and (k) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case You must use the above option which includes (j) only).

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, *WE ASK YOU TO OBTAIN* A SECOND AND/OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, *AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S), OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION,* WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND *NEI-*

THER OF **THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.**

C. **NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.**

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless we determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1–Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We Subsequently Determine the in-patient admission to have been Medically Necessary and Appropriate, We will make payment as otherwise provided in this policy.

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy

Arthroscopy

Bunionectomy

Carpal Tunnel Surgery

Cesarean Section

Cholecystectomy

Coronary Artery Angioplasty

Coronary Artery Bypass Graft

Esophagoscopy

Excision of Intervertebral Disk

Gastroduodenoscopy

Hip Replacement

Hysterectomy

Knee Replacement

Lower Back Surgery

Mastectomy

Meniscectomy

Myringotomy

Pacemaker Implantation

Prostatectomy

Rhinoplasty

Septectomy with Rhinoplasty

Tonsillectomy

Tubal Transection and/or Ligation

Tympanoplasty

Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization

CAT SCAN

Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care

Skilled Nursing Care

Maternity Care (See STEP 2(a))

Hospice Care

Infusion Therapy

STEP 2–Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care,** You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, **or the next business day, whichever is later,** as well as put in writing to You, what specific information is needed to make that Determination. **In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.**

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this policy.

STEP 3–Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may require that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second

opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PERFORMANCE OF THE PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"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 Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;

b. the Covered Person's attending Practitioner; and

c. Us.

The 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:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and

d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person 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 the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We Determine to be Experimental or Investigational.

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the requirements of the "Utilization Review" section will not apply.]]

X. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

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

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

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

Custodial care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

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

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

Extraction of teeth except as otherwise specifically covered.

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

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

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

Herbal medicine.

Hypnotism.

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

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

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

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

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Primary Care Services.

Non-Prescription Drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for services;
—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;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;

—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate except as otherwise stated in this Policy; or
—which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the covered person (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vitamins and dietary supplements.

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 used to eliminate baldness.

XI. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the recognized Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and

why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

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

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

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

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XII. [XIII.] RIGHT TO RECOVERY— THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy 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 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 paid benefits and these amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15–97.

The repayment will be equal to the amount of benefits paid 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.

We shall require the return of health benefits paid 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.

The repayment agreement shall 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 Policy 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.]

XII. [XIV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;

(b) the Policyholder's application, a copy of which is attached to the Policy;

(c) any riders, endorsements or amendments to the Policy; and

(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

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

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

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

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY-RENEWAL PRIVILEGE

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

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

(a) nonpayment of Premiums (coverage will end as of the end of the grace period);

(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);

(d) You become eligible either for Medicare, or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);

(e) You become covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the new Individual Health Benefits Plan takes effect provided You notify Us of the replacement within 30 days after the effective date of the new Plan);

(f) non-renewal as authorized by the Board (Coverage will end on the date determined by the Board

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

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

CONTINUING RIGHTS

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

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

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

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

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

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

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

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

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[IN-NETWORK AND OUT-OF-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

An In-Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out-of-Network Provider may be different than our In-Network Provider Allowance; also, an Out-of-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

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

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this policy as of each Anniversary Date, if this Policy stays in force by the payment of premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

    If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a).
Public Notice: Action on petition for rulemaking.
See: 28 N.J.R. 2413(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit D.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate options for Sections III and V.

EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

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

[CARRIER]

INDIVIDUAL HEALTH BENEFITS PLAN E

(New Jersey Individual Health Benefits Plan E)

Policy Term. The Policy takes effect on [_________], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

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

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan E.

[Dividends are apportioned each year.]

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page [20].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

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

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Policy. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

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

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

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

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

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

COVERED CHARGE. 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 Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while you are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
(1) Spouse;
(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school. (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

Except as allowed under the Primary Care Services provision of the CHARGES COVERED WITH SPECIAL LIMITATIONS section, diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily for a medical purpose;

(c) mainly and customarily used to serve a medical purpose;

(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your particular condition as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

—The American Medical Association Drug Evaluations;

—The American Hospital Formulary Service Drug Information; or

—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.

FACILITY. A place We are required by law to recognize which:

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

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

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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;

(b) accredited for its stated purpose by the Joint Commission; or

(c) licensed, certified, or accredited by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission;

(b) approved as a Hospital by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

[**IN-NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

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

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

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

[**OUT-OF-NETWORK PROVIDER.** A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Covered Person; and

(b) with or without interruption of coverage.

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

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

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

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

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

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

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

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

PRIMARY RESIDENCE. The location where You reside for the majority of a Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

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

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

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care,
(b) approved for its stated purpose by Medicare or
(c) licensed, certified, or accredited by the state in which it operates.

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

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, 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 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 task 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 of the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for only one person.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Policy for You and Your Spouse.

[(e) **CHILD(REN) COVERAGE**—coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(b) **SPOUSE**—Your Spouse, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.

(c) **CHILD**—Your Child, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below, and who qualifies as a Dependent, as defined in this Policy.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other Coverage has been terminated.

(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, CO-PAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%

OTHER COVERED CHARGES—10%

COINSURANCE CAP—After $1,500/Covered Person, $3,000/ family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE

for Primary Care Services	None
for immunizations and lead screening for children	None
for all other Covered Charges	
per Covered Person	[$150, $500, $1,000]
per Covered Family	[$300, $1,000, $2,000]

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to cash deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES

Physical Therapy	30 Visits per Covered Person per Benefit Period
Occupational Therapy	30 Visits per Covered Person per Benefit Period
Speech Therapy	30 Visits per Covered Person per Benefit Period
Cognitive Rehabilitation Therapy	30 Visits per Covered Person per Benefit Period
	Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our Pre-Approval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage .... [$]
For Adult and Child(ren) Coverage .... [$]
For Family Coverage .... [$]
For Husband and Wife Coverage .... [$]
[For Child(ren) Coverage .... $]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the 45th day following the date of the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

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

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

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductibles are shown in the Schedule of Benefits section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

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

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

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

VI. COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE "UTILIZATION REVIEW" SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

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

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

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits

During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];

(b) Therapy Services;

(c) medical social work;

(d) nutrition services;

(e) home health aide services;

(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and

(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
   —ordered by Your Practitioner;
   —included in the home health care plan; and
   —furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

(b) The services and supplies must be: (a) ordered by Your 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. 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.

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

(d) 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.

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.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other copayments, and coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital Care following cesarean section delivery. These covered charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However these charges are subject to either the attending Practitioner determining that in-patient care is medically necessary or the mother requesting the in-patient care.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 are not Pre-Approved by Us are Non-Covered Charges.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Therapy and Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the "Utilization Review" section of this Policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a genital abnormality or developmental anomaly.

We cover reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

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

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

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are insured 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.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

We will not provide benefits under this Policy 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.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month Pre-Existing Condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Policy measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time waiver and/or credit.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Primary Care Services. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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 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 Department of Health. These charges are not subject to the Deductible.

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 Non-Covered Expense.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period per Covered Person for each of the following Therapy Services: Physical Therapy, Occupational Therapy, Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ): We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas

(i) Allogenic Bone Marrow

**[(j) Autologous Bone Marrow and Dose-Intensive Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Subject to Our written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Expenses.]

**[(j) 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.

(k) 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.]

****NOTE TO CARRIERS:** P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (j) and (k) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case you must use the above option which includes (j) only).

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

VIII. UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF *WE ASK YOU TO OBTAIN* A SECOND AND/OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, *AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S), OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION,* WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND *NEITHER OF* THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1–Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We Subsequently Determine the in-patient admission to have been Medically Necessary and Appropriate, We will make payment as otherwise provided in this Policy.

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy

Arthroscopy

Bunionectomy

Carpal Tunnel Surgery

Cesarean Section

Cholecystectomy

Coronary Artery Angioplasty

Coronary Artery Bypass Graft

Esophagoscopy

Excision of Intervertebral Disk

Gastroduodenoscopy

Hip Replacement

Hysterectomy

Knee Replacement

Lower Back Surgery

Mastectomy

Meniscectomy

Myringotomy

Pacemaker Implantation

Prostatectomy

Rhinoplasty

Septectomy with Rhinoplasty

Tonsillectomy

Tubal Transection and/or Ligation

Tympanoplasty

Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization

CAT SCAN

Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care

Skilled Nursing Care

Maternity Care (See STEP 2(a))

Hospice Care

Infusion Therapy

STEP 2–Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care,** You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, **or the next business day, whichever is later,** as well as put in writing to You, what specific information is needed to make that Determination. **In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.**

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3–Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may require that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PERFORMANCE OF THE PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4–Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF *NEITHER* THE SECOND *NOR* THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY *50%* PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"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 Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The 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:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person 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 the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We Determine to be Experimental or Investigational.

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine

whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the requirements of the "Utilization Review" section will not apply.]]

X. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

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

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request for Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

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

Custodial care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically covered.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

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

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

Extraction of teeth except as otherwise specifically covered.

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

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

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

Herbal medicine.

Hypnotism.

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

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

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

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

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Primary Care Services.

Non-Prescription Drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Approval".

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:

- eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for the services;
- 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;
- for which You would not have been charged if You did not have health care coverage;
- for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- for which the Provider has not received a certificate of need or such other approvals as are required by law;
- furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- in an amount greater than a Reasonable and Customary charge;
- needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
- provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
- which are specifically limited or excluded elsewhere in this Policy;
- which are not Medically Necessary and Appropriate except as otherwise stated in this Policy; or
- which You are not legally obligated to pay.

Special medical reports not directly related to treatment (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vitamins and dietary supplements.

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 used to eliminate baldness.

XI. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagno-

sis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;

(b) Policyholder's [identification] number;

(c) date of service;

(d) claim number;

(e) Provider's name; and

(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information. We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

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

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XII. [XIII.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy 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 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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We shall require the return of health benefits paid 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.

The repayment agreement shall 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 Policy 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or Federal law and that other law precludes repayments.]

XIII. [XIV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;

(b) the Policyholder's application, a copy of which is attached to the Policy;

(c) any riders, endorsements or amendments to the Policy; and

(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or that of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

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

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

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

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. Termination by Request—If You want to replace this Policy with

another Individual Health Benefits Plan, You must give Us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

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

(a) nonpayment of Premiums (coverage will end at the end of the grace period);
(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);
(d) You become eligible either for Medicare, or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);
(e) You become covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the new Individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan);
(f) non-renewal as authorized by the Board (coverage will end on the date determined by the Board).

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

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

CONTINUING RIGHTS

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

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

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

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

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

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

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

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

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[IN-NETWORK AND OUT-OF-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

An In-Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out-of-Network Provider may be different than our In-Network Provider Allowance; also, an Out-of-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

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

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this policy as of each Anniversary Date, if this Policy stays in force by the payment of premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT F

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

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

[CARRIER]
HEALTH MAINTENANCE ORGANIZATION
BENEFITS PLAN
(New Jersey HMO Health Benefits Plan)

Contract Term. The Contract takes effect on [__________], the Contract Effective Date. The term of this Contract starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Contract. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Contract.

Renewal Provision. Subject to all Contract terms and provisions, including those describing Termination of the Contract, You may renew and keep this Contract in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Contract. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Contract.

Premiums. We may only change the Premium schedule for this Contract if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this HMO Health Benefits Plan.

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I. 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 You to understand what services are provided. Information about the services provided under this Contract begins on page 22.

ALCOHOLISM. Abuse of or addiction to alcohol.

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

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

[ASSOCIATED MEDICAL GROUPS. Any Medical Group with which we contract directly to provide Covered Services to Members including the [ ]].

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this Contract.

BIRTHING CENTER. A Facility which mainly provides care and treatment for people 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 Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

It must also:

(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 if it is part of a Hospital.

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

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

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

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

[**COINSURANCE.** The percentage of a Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered Services.]

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

CONTRACTHOLDER. The person who purchased this Contract.

CONTRACT TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Contract is renewed each one-year period thereafter.

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

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

(a) furnished or ordered by a recognized health care Provider;

(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Primary Care Services;

(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and

(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:

(1) Spouse;

(2) A Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Contract provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school. (We can ask you to provide periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Contract's age limit, if:

(1) the Child remains unmarried and unable to support himself or herself;

(2) the Child's condition started before the Child reached this Contract's age limit;

(3) the Child became insured before the Child reached this Contract's age limit, and stayed continuously insured until the Child reached such limit; and

(4) the Child depends on You for most of his or her support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days form the date the Child reaches this Contract's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily for a medical purpose;

(c) mainly and customarily used to serve a medical purpose;

(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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your particular condition as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the 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:

—The American Medical Association Drug Evaluations;

—The American Hospital Formulary Service Drug Information; or

—The United States Pharmacopeia Drug Information.

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

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

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

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.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

[**HEALTH CENTER (or HEALTH CARE CENTER)**—Any place operated by or on behalf of an HMO where a [Network] [Participating] [Provider] [Practitioner] Provides Covered Services and Supplies to Members.]

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 or reduce Hospital stays. The Agency must be licensed by the state in which it operates, be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It carries out its stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare;

(b) accredited for its stated purpose by the Joint Commission; or

(c) licensed, certified, or accredited by the state in which it operates.

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

(a) accredited as a hospital by the Joint Commission;

(b) approved as a Hospital by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

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 for Substance Abusers or Alcoholics is not a Hospital.

A specialty Facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Member's body and all complications arising from that damage.

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

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

[**MAINTENANCE DRUG.** A Prescription Drug used for the treatment of chronic medical conditions including but not limited to: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders.]

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis, strokes, convulsions, severe burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

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 Social Security Act, as amended from time to time.

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

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

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. The Facility must carry out its stated purpose under all relevant state and local laws, and be:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services.

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

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife 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. You, if You are registered at a recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PRACTITIONER. A person who:

(a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
(b) provides medical services which are within the scope of his or her license or certificate and which are covered by this Contract.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-

term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay). For the purpose of benefit limitations, Partial Hospitalization days are considered as Outpatient visits.

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Contract:

(a) as a Member; and

(b) with or without interruption of coverage.

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

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

PREMIUM. The periodic charges due under this Contract which the Contractholder must pay to maintain this Contract in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Contract starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the exclusions section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Contract.

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

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

PRIMARY RESIDENCE. The location where You reside for a majority of the Calendar Year with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intent to return, will not interrupt Your Primary Residence in New Jersey.

PROVIDER. A Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] [or Health Center] or that directs You 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 carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;

(b) approved for its stated purpose by Medicare; or

(c) licensed, certified, or accredited by the state in which it operates.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas 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 nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (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 Accidently Injured people who do not need to be in a Hospital. It carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

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

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.

SPOUSE. An individual legally married to the Contractholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. The Facility must carry out its stated purpose under all relevant state and local laws, and be:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

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

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

(We will recognize it if it) carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
(b) approved for its stated purpose by Medicare; or
(c) licensed, certified, or accredited by the state in which it operates.

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

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

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Contract. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

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

II. ELIGIBILITY

TYPES OF COVERAGE

A Contractholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Contract for only one person.
(b) **FAMILY COVERAGE**—coverage under this Contract for You and Your Dependent(s).
(c) **ADULT AND CHILD(REN) COVERAGE**—coverage under this Contract for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Contract for You and Your Spouse.
[(e) **CHILD(REN) COVERAGE**—coverage under this Contract for a Child or multiple Children who are members of the same household and who depend on the Contractholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE CONTRACTHOLDER**—You, if Your Primary Residence is in the designated service area in the State of New Jersey, You are not covered under another individual health benefits plan, and You are not eligible for a Group Health Benefits Plan, Medicare or except as provided below.
(b) **SPOUSE**—Your Spouse, whose Primary Residence is in the designated service area in the State of New Jersey, who is not covered under another individual health benefits plan, and who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below.
(c) **CHILD**—Your Child, whose Primary Residence is in the designated service area in the State of New Jersey, who is not covered under another individual health benefits plan, who is not eligible for Medicare, or a Group Health Benefits Plan except as provided below, and who qualifies as a Dependent, as defined in this Contract.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN**—You and/or Your Dependents are eligible for Coverage under this Contract if this Contract replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other Coverage has been terminated.
(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN**—You and/or Your Dependents may be eligible for Coverage under this Contract only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS CONTRACT

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Contract is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of the Child's eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Contract.

III. SCHEDULE OF SERVICES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS CONTRACT ARE SUBJECT TO ALL CO-PAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER BENEFIT PERIOD, UNLESS OTHERWISE STATED. BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

FACILITY BENEFIT—Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period.

OUTPATIENT—$15 Copayment/visit

PRACTITIONER SERVICES:

INPATIENT—None.

OUTPATIENT—$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM—$50 Copayment/visit/Member (credited toward Inpatient admission if admission occurs within 24 hours as the result of the emergency).

ALCOHOLISM:

OUTPATIENT—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits.

AMBULATORY SURGERY—$15 Copayment/visit.

BIRTHING CENTERS—$15 Copayment/visit.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CHARGES—Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE)—$25 Copayment/initial visit.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT/PARTIAL HOSPITALIZATION—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500 Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits or Partial Hospitalization days.

PODIATRIC—$15 Copayment/visit (excludes Routine Foot Care).

PRE-ADMISSION TESTING—$15 Copayment/visit.

PRESCRIPTION DRUG—50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES—$15 Copayment/visit.

PRIMARY CARE SERVICES—$15 Copayment/visit.

SECOND SURGICAL OPINION—$15 Copayment/visit.

SPECIALIST SERVICES—$15 Copayment/visit. You must have a Referral from Your Primary Care Physician.

SKILLED NURSING CARE—Unlimited days, if preapproved.

THERAPEUTIC MANIPULATION—$15 Copayment/visit for a maximum of 30 visits/Benefit Period.

THERAPY SERVICES—$15 Copayment/visit.

X-RAY & LAB (OUTPATIENT) —$15 Copayment/visit.

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY PHYSICIAN, CARE MANAGER OR HEALTH CENTER AS APPLICABLE. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Contract are [shown in the Contract's Schedule of Premium Rates]:

For Single Coverage	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] at the times and in the manner established by the provision of this Contract entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

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 was included in the Premiums paid for the two-month period immediately after the date the Member's coverage has ended.

(b) the amount of any claims paid or the value of any services provided to You or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Contract. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Contract is in force in order for this Contract to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period, [this Contract will continue in force without premium payment during the grace period and this Contract will end when the grace period ends.] [coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.] [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.]

REINSTATEMENT

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

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the [Premium Rates and Provisions section of the Contract] [Contracts Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Contract is changed:

  (1) by amendment of the Contract; or

  (2) by reason of any provision of law or any government program or regulation;

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

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

V. COVERED SERVICES AND SUPPLIES

You are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by You of applicable Copayments as stated in the applicable Schedule of Services.

(a) **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] [Health Center] or [Care Manager]:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Home visits** by your Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;

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c. Routine gynecologic exams and related services;
d. Routine ear and hearing examination; and
e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of your employment).

4. Diagnostic Services.
5. Casts and dressings.
6. Ambulance Service when certified in writing as Medically Necessary and Appropriate by Your [Primary Care Physician] [or Care Manager] and approved in advance by Us [or the Care Manager].
7. Infertility Services except where specifically excluded in this Policy.
8. Prosthetic Devices and Durable Medical Equipment when ordered by Your Primary Care Physician [or Care Manager] and arranged through Us. 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 Your 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. Prescription Drugs and contraceptives which require a Practitioners prescription and the following non-prescription drugs and supplies: insulin needles and syringes and glucose test strips and lancets; colostomy bags, belts and irrigators.
10. Nutritional Counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Primary Care Physician and approved in advance by Us.

(b) **SPECIALIST PRACTITIONER BENEFITS.** Services of a Specialist Practitioner are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office[, or Health Center] or at a [Network] [Participating] Hospital outpatient department during office or business hours upon prior written referral by Your Primary Care Physician [or Care Manager].

(c) **INPATIENT HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] [Participating] Practitioner upon prior written referral from Your Primary Care Physician [Care Manager], only at [Network] [Participating] Hospitals and [Network] [Participating] Practitioners (or at [Non-Network] [Non-Participating] Facilities non-participating facilities upon prior written authorization by Us); however, [Network] [Participating] Skilled Nursing Center benefits are limited to those which are Medically Necessary and Appropriate and which constitute Skilled Nursing Care:

1. Semi-private room and board accommodations
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 Participating Hospital following a vaginal delivery; and
b. a minimum of 96 hours of in-patient care in a Participating Hospital following a cesarean section.

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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.

2. Private accommodations will be provided only when Medically Necessary and Appropriate as certified by Your attending Practitioner in concurrence with Your Primary Care Physician [or Care Manager] and approved in advance by Us. If You occupy a private room without such certification You shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] [Participating] Hospital or the [Network] [Participating] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of extensive 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
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 Medically Necessary and Appropriate as certified by the [Network] [Participating] Specialist Practitioner or other attending physician in concurrence with Your Primary Care Physician [or Care Manager] and approved in advance by Us.
21. The following transplants, when Medically Necessary and Appropriate: Cornea, Kidney, Lung, Liver, Heart, Heart-Lung, Heart Valves, Pancreas.
22. Allogenic bone marrow transplants.

**[23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, and Breast Cancer when approved in advance by Us, if You are 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.]

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****NOTE TO CARRIERS: P.L. 1995 c.100 requires that Autologous Bone Marrow Transplants, associated dose-intensive chemotherapy and peripheral blood stem cell transplants coverage as set forth in the option which includes (23) and (24) be offered to New Jersey residents. You may offer the coverage by including this option in all of Your New Jersey Individual Health Coverage Plans (in which case you must use the above language) or you may offer the coverage as an optional rider utilizing Exhibit R to N.J.A.C. (in which case you must use the above option which includes (23) only).**

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

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits or Partial Hospitalization days during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by Your Primary Care Physician [or Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by Your Primary Care Physician [or Care Manager] for up to sixty (60) more Outpatient visits or Partial Hospitalization days by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** You 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. **Repeat Detoxification Treatment.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating] Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of substance abuse services.
4. Court-ordered Substance Abuse or Mental or Nervous Conditions admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as described above.

(e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a [Participating Provider] [Network Practitioner] at Practitioner's office[, Health Center] or at a [Network] [Participating] Substance Abuse Center upon prior written referral by Your Primary Care Physician [or Care Manager].

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by Your [Primary Care Physician] [or Care Manager] for the abuse of or addiction to alcohol. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by Your Primary Care Physician [or Care Manager] 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.** You 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, and referral services for Substance Abuse or addiction. 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. **Repeat Detoxification Treatment.** Repeated detoxification treatment for chronic Alcoholism will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating] Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of Alcoholism services.
4. Court-ordered alcohol admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

(f) **MEDICAL EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by Your Primary Care Physician [or Care Manager] in the event of a Medical Emergency as Determined by Us [or the Care Manager].

1. Your Primary Care Physician [or Care Manager] 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 Your health, You shall call Your Primary Care Physician [or Care Manager] [or Health Center] [or Us] prior to seeking Medical Emergency treatment.
2. We will cover the cost of Medical Emergency and Medical services performed within or outside Our service area without a prior written referral only if:
   a. Our review determines that Your symptoms were severe and delay of treatment would have been detrimental to your health, the symptoms occurred suddenly, and You sought immediate medical attention.

   A near-term delivery is not a Medical Emergency.

   b. The service rendered is provided as a benefit under this Contract and is not a service which is normally treated on a non-emergency basis; and
   c. We and Your Primary Care Physician [or Care Manager] are notified within 48 hours of the Medical 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. You shall be responsible for payment of services received unless We Determine that Your failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event You are hospitalized in a [Non-Participating] [Non-Network] Facility, coverage will only be provided until You are medically able to travel or to be transported to a [Network] [Participating] Facility. If You elect to continue treatment with [Non-Network] [Non-Participating] Providers, We shall have no responsibility for payment beyond the date You are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary and Appropriate, We will cover the reasonable cost as Determined by Us. Reimbursement may be subject to payment by You of all Copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to the [Network] [Participating] Provider.
4. Coverage for Medical Emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after You have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or You shall be responsible for payment.
5. The Copayment for a Medical Emergency room visit will not apply in the event that You were referred for such visit by Your Primary Care Physician [or Care Manager] for services that could have been rendered in the Primary Care Physician's office or if You are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(g) **THERAPY SERVICES.** [The following Services are covered when rendered by a [Network] [Participating] Provider upon prior written referral by Your Primary Care Physician.

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] [Participating] Provider by Your Primary Care Physician [or Care Manager]. This benefit consists of treatment for a 60 day period per incident of Illness or Accidental Injury, beginning with the first day of treatment, provided that Your Primary Care Physician [or Care Manager] certifies in writing that the treatment will result in a significant improvement of Your condition within this time period and treatment is approved in writing by Us.
2. Chelation therapy, Chemotherapy treatment, Dialysis treatment, Infusion therapy, Respiration therapy, and Radiation therapy.

(h) **HOME HEALTH BENEFITS.** The following services are covered when rendered by a [Network] [Participating] Provider, including but not limited to a [Network] [Participating] Home Health Agency, as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of Your Primary Care Physician [or 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 You 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 Your medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if You are terminally Ill with life expectancy of six months or less, 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 more cost effective setting in which to provide appropriate care.

(i) **THERAPEUTIC MANIPULATION.** The following services are covered when rendered by a [Network] [Participating] 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 Benefit Period. Services and supplies beyond 30 visits are not covered.

VI. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

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

Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.

Any therapy not included in Our definition of Therapy Services.

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

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Contract; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domicilary care.

Dental care or treatment, including appliances.

Dose-Intensive Chemotherapy, except as otherwise stated in this Policy.

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

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

Extraction of teeth, including bony impacted teeth.

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

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider unless You were referred to the Provider by Your Primary Care Physician.

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

Herbal medicine.

Hypnotism.

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

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

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

Methadone maintenance.

Non-Prescription Drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Nutritional counseling and related services except as otherwise stated in this Policy.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Contract for twelve months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition. We waive this limitation for Your Pre-Existing Condition if, under Medicaid or a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no more than 30 days lapse in coverage, measured from the last date the prior coverage was in force on a premium paying basis, You have been treated or diagnosed by a Practitioner for a condition under that plan or satisfied a 12 month preexisting condition limitation for a condition covered by that plan. Similarly, we will credit the time You were previously covered under Medicaid or a group or individual health benefits plan delivered or issued for delivery in the United States for a condition covered by that Plan, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of this Contract, measured from the last date the prior coverage was in force on a premium paying basis.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1–4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 30 days after adoption or placement for adoption. Additionally this limitation does not apply to any new benefits mandated by statute or regulation once you have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

[Prescription Drugs: We do not cover an initial prescription or refill that exceeds the lesser of: the amount prescribed by the Participating Provider and the amount shown below that applies to the Prescription Drug:

(a) For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90) day supply.

(b) For all other Prescription Drugs:

(i) a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or

(ii) sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;

(iii) a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointments, enemas, etc.); or

(iv) one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or

(v) one (1) vial containing no more than fifteen (15) milliliters of any otic or ophthalmic product; or

(vi) two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or

(vii) three (3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

(a) dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or

(b) dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

A Prescription Drug that is prescribed for injectable use, other than injectable insulin on prescription only, is not covered.

Allergy and biological sera, therapeutic devices or appliances are not covered as Prescription Drugs.]

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

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, related diagnostic testing, self-care and self-help training.

Services or supplies:

— eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
— 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;
— for which You would not have been charged if You did not have health care coverage;
— for Your personal convenience or comfort, including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
— for which the Provider has not received a certificate of need or such other approvals as are required by law;
— furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
— needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation;
— provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medi-

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cal Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) provided in a hospital that is located outside of the United States and Puerto Rico; or (d) as we are required by law to cover;
- provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
- provided by a licensed pastoral counselor in the course of his or her counselor's normal duties as a pastor or minister;
- received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Contract;
- which are specifically limited or excluded elsewhere in this Contract;
- which are not Medically Necessary and Appropriate except as otherwise stated in this Contract;
- which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Member (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Transplants, unless otherwise specifically covered, and non-human organ transplants.

Transportation; travel.

Vitamins and dietary supplements.

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 used to eliminate baldness.

VII. GRIEVANCE PROCEDURE

[**Grievance Procedure:** Variable by Carrier as approved by the State of New Jersey.]

VIII. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"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 or a 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 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 paid benefits or arranged [or provided] services or supplies and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15–97.

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.

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.

The repayment agreement shall 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 pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Member to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Member 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.

This provision shall not be construed or applied so as to require the return of any benefit properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.

IX. GENERAL PROVISIONS

AMENDMENT

The Contract may be amended, at any time, without Your 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 an officer of [Carrier] has 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 an officer of [Carrier].

(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 an office of [Carrier].

(c) if a change is required by [Carrier], 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 or by an officer of [Carrier].

ASSIGNMENT

No assignment of transfer by You of any of Your interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Contract will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made. Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Contract.

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 or; 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 or as may otherwise be provided by law may not be disclosed without the Member's written consent.

CONFORMITY WITH LAW

If the provisions of the Contract do not conform to the requirements of any state or federal law that applies to the Contract, the Contract is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

CONTINUATION OF COVERAGE

If you die while this Contract is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Contract for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Contract provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONTINUING RIGHTS

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

CONVERSION PRIVILEGE

If your Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Contract ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Contract will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

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

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Contractholder, coverage may be terminated for the Contractholder as well as any of the Contractholder'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 Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this 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, except to refund the amount of the unearned prepaid Premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provisions of services, taking into account the impact of the event.

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 You shall be used in contesting the validity of Your coverage or in denying a claim for benefits after such coverage has been in force for two years during Your lifetime.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, Facility or agency is our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, Facility or agency.
2. Neither the Contractholder nor any Member is our agent, representative or employee, or an agent or representative of any Contract Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. Contract Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contractholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the contract until 60 days after You file 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.

LIMITATION ON SERVICES

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

MEDICAL NECESSITY

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

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.

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

OTHER RIGHTS

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

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

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

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

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

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.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey within our authorized Service Area. We reserve the right to require proof of Your Primary Residence.

We will cancel this Contract if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

REFERRAL FORMS

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Grievance Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Grievance Procedure. We reserve the right to expedite the Grievance Procedure. If the Grievance Procedure results in a decision upholding position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this 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 Grievance Procedure, to terminate this Contract in accordance with Section IX. 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 Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits 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

HMO is entitled to receive from any provider of services to Contract Member such information HMO deems to administer this Contract subject to all applicable confiden-

tiality requirements as defined in this Contract. By accepting coverage under this Contract, Contractholder, for the Contractholder, and for all Dependents covered hereunder, authorizes each and every Practitioner who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician and/or a Health Center].

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

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance policy, You have two options under the terms of Your motor vehicle insurance policy. The option You select will also determine coverage of any family member covered under that policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance policy or under similar provisions of a motor vehicle policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

(b) You may choose to have primary coverage for such services provided by this Contract.

If You choose this option, We will provide benefits for any Covered Services and Supplies incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Contract.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primary between the motor vehicle insurance policy and this Contract, this Contract will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

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

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE

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

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

(a) nonpayment of Premiums ([coverage will end as of the end of the grace period] [coverage will end as of the end of the period for which premium has been paid]);
(b) fraud or misrepresentation by You or Your Dependents (coverage will end immediately);
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility (coverage will end immediately);
(d) You become eligible either for Medicare, Medicaid or the date You first become eligible to participate in a Group Health Benefits Plan (coverage will end at 12:01 a.m. on the date of eligibility for Medicare or eligibility for the group plan);
(e) You became covered under another individual health benefits plan (coverage will end at 12:01 a.m. on the date the Individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan);
(f) non-renewal as authorized by the Board (overage will end on the date determined by the Board).

THE CONTRACT

The entire Contract consists of:

(a) the forms shown in the Tables 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.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If you do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will cover services only if we Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage Your treatment for a [Mental or Nervous Condition, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

Section Page
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered or actually covered under:
   (a) a group health benefits plan that provides same or similar coverage for hospital and medical expenses;
   (b) Medicare.
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for group coverage, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE DEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

[COMPLETE SECTIONS 1, 2, 3 [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1—Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you must attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the application or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked only if you wish to add or remove a dependent from the plan.

Section 2—Complete all information.

Section 3—Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4—This information is required. Please complete all information.

[Section 5—For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5, 6]—Applicant must sign this section and date this form or it will not be processed.

Section [6, 7]—Completion of this section is optional.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by (carrier) after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.
3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].
4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

[5. As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by (Carrier), must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]

[6. [If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]

[7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]

[8. Applicant acknowledges that (Carrier's) participating providers, including all participating primary care physicians, are independent contractor and are not agents or employees of (Carrier).]

Please print in ink all information requested on this application.

1. Eligible Persons to be enrolled. (Note: Dependent children may be covered under their parents contract only while unmarried and until [they attain] age 19 or 23, if full time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This next section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	Birthdate MO DAY YR	Sex M or F	Social Security Number
Applicant 1. [ ] Add [ ] Remove					__/__/__-__/__-__/__/__/__
Spouse					

2.
[ ] Add [ ] Remove ___/___/___-___/___-___/___/___/___

Child
3.
[ ] Add [ ] Remove ___/___/___-___/___-___/___/___/___

Child
4.
[ ] Add [ ] Remove ___/___/___-___/___-___/___/___/___

Child
5.
[ ] Add [ ] Remove ___/___/___-___/___-___/___/___/___

* Attach sheet to list additional children. Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? [ ] Yes [ ] No
If yes, who and at what address?

Explain the circumstances.

If any dependent's last name is different from yours, explain the circumstances.

2. **PRIMARY RESIDENCE** (Note: You must reside in New Jersey for the majority of a calendar year with the intention of making New Jersey your home and not for temporary purposes.]

Street Apt City State Zip

TELEPHONE NUMBER

Home ( )___-___
Work ( )___-___
Best place to call during day [ ] Home [ ] Work]

Are you a resident of the State of New Jersey? [ ] Yes [ ] No
Do you maintain a residence in any other state? [ ] Yes [ ] No
If "Yes": (a) Name of state ______________________
(b) How much time do you spend there each year? ______________________

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 30 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): ______________________
Name of Carrier: ______________________
Policy Number: ______________________
Type of Coverage: Check all that apply.
___ Group ___ Individual
___ Indemnity ___ HMO ___ PPO ___ Point of Service
___ Other (Specify) ______________________
Plan Information
Deductible Amount: ___________
Coinsurance: ___________
Copayment: ___________
Initial Effective Date: ___________ Termination Date: ___________

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): ______________________
Name of Carrier: ______________________
Policy Number: ______________________
Type of Coverage: Check all that apply.
___ Group ___ Individual
___ Indemnity ___ HMO ___ PPO ___ Point of Service
___ Other (Specify) ______________________
Plan Information
Deductible Amount: ___________
Coinsurance: ___________
Copayment: ___________

Initial Effective Date: ____________________Termination Date: ______________]]

3. **COVERAGE** (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY FAMILY) IN: (Only one may be selected) [(For Plans B, C, D, and E select one deductible option.)]

PLAN B [[ ]Indemnity][[ ]Point of Service][[ ]Preferred Provider] Deductible $500 __ $1000 __
PLAN C [[ ]Indemnity][[ ]Point of Service][[ ]Preferred Provider] Deductible $1000 __ $2500__ [$1500__ $2250 __]
PLAN D [[ ]Indemnity][[ ]Point of Service][[ ]Preferred Provider] Deductible $500 __ $1000__ [$1500__ $2250__]
PLAN E [[ ]Indemnity] [[ ]Point of Service][[ ]Preferred Provider] Deductible $500 __ $1000 __
[HMO Plan [$10] $15 [$20] copayment] Well Child Care Option [ ] Yes [ ] No

Type of Contract: [ ] Single
[ ] Family
[ ] Adult & Child(ren)
[ ] Husband/Wife
[[ ] Child(ren)]

Requested Effective Date—[Must be the 1st or 15th of the month]: ____________________

Type of Activity:

[ ] New Subscriber

[ ] Converting from existing [carrier] plan
ID # ______________

[ ] Add/Remove Dependent
Reason ______________
Date of Event ______________

[ ] Name change from ________ to ________

[[ ] Change of Primary Care Physician or Gynecologist]

[[ ] Change of Health [Care] Carrier from _____ to _____]

[[ ] Change of Primary Care Physician at Health [Care Center]

[ ] Withdrawal from Coverage
Date of Event ______________

SELECT THE PAYMENT PLAN YOU DESIRE

[ ] Monthly [[ ] Quarterly [[ ] Semi-Annually]

[PAYMENT MODE:
[ ] Check
[ ] Money Order
[ ] Credit Card Type ___________ No. ___________ Exp. Date ___________
[ ] Automatic Bank Draft (attach voided check)
[ ] Other ___________ Amount $ ___________]

4. **OTHER HEALTH CARE COVERAGE** [Note: In some situations, if you are eligible for **or have** other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other family members become eligible for or become covered under other health benefits coverage after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.]

Are you employed? [ ] Yes [ ] No If yes, please give name and address of your employer.

Are you eligible for other health benefits coverage? [ ] Yes [ ] No
(i.e., coverage under your employer's health benefits coverage **or** Medicare.

If yes, give name and policy no. of other carrier or type of coverage.

Are other family members eligible for coverage? If yes, specify.

Do you or other family members currently have any other health care coverage? ___ Yes ___ No

If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy certificate:.

Are you replacing existing coverage [ ] Yes [ ] No

If yes, give name and policy no. of other carrier, initial effective date, date of coverage, date of termination, and specify those covered by policy.

If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced. __________

[Have you or your dependents ever been a member of [carrier]?]

[If yes, under what name and social security no?]

[Where? [carrier] of]

[PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
1. a.	Alcoholism, Drug Abuse	___	___
b.	Arthritis	___	___
c.	Blood Disorder	___	___
d.	Back or Neck Disorder, Injury or Pain	___	___
e.	Cancer or Tumors	___	___
f.	Diabetes	___	___
g.	Gastro or Intestinal Disorder	___	___
h.	Heart Disorder or Condition or Chest Pain	___	___
i.	High Blood Pressure	___	___
j.	Kidney or Liver Disorder	___	___
k.	Lung or Respiratory Disorder	___	___
l.	Mental or Nervous Disorder	___	___
m.	Paralysis, Stroke or Epilepsy	___	___
n.	Does Pregnancy Exist Expected Due Date:	___	___

2. During the past 6 months, have you or any dependent to be covered:

		Yes	No
a.	been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	___	___
b.	been advised to have treatment or surgery or testing that has not been done?	___	___
c.	been admitted to a hospital or other health care facility as an inpatient?	___	___
d.	taken prescribed medications?	___	___

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and Letter	Name of Person	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners
					]

5.**PROVIDER SECTION**

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO	HEALTH CENTER* (If applicable)	[GYNECOLOGIST OFFICE NO.]	ESTABLISHED PATIENT	PRIMARY CARE PHYSICIAN CHANGE	HEALTH CENTER CHANGE
1 Applicant			[ ] Yes [ ] No		[ ]	[ ]
2 Spouse			[ ] Yes [ ] No		[ ]	[ ]
3 Child			[ ] Yes [ ] No		[ ]	[ ]
4 Child			[ ] Yes [ ] No		[ ]	[ ]
5 Child			[ ] Yes [ ] No		[ ]	[ ]

[Statewide Physician Network [ ] Health Carrier [ ]]

* When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.

[5.][6.] **AUTHORIZATION AND CERTIFICATION**

I hereby apply to (carrier) for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and Iaccept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995 c.100. [ ] Accept [ ] Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, (carrier) may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to (carrier or its assignee) information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to (carrier or its assignee).

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside within the (carrier) service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that (carrier) will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application (carrier) can cancel this contract as of the original effective date.

Applicant's Signature: ____________________ Date Signed: ____________________
Spouse' Signature: ____________________ Date Signed: ____________________
Preparer's Signature: ____________________ DOI License # __________ Date Signed: ____________________

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

[6.][7.] INCOME HOUSEHOLD

Completion of this section is optional. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance of coverage.

[ ] under $20,000 [ ] $20–$29,999 [ ] $30–$39,999 [ ] $40–$49,999
[ ] $50–$59,999 [ ] $60,000 and above

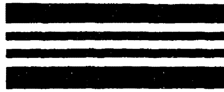
For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA



AF· ?OVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

ST11788 HCFA-1500 (LASER 12-90 OCR BC)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

EXHIBIT I

DUE FROM PATIENT ►

NOTICE TO THE PATIENT The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

EXHIBIT J

Loss Ratio Report Form New Jersey Individual Health Coverage Program

Reporting Year 19____, for the Preceding Calendar Year Ending December 31, ____

Name of Carrier __________ NAIC # __________

Address ____________________

____

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20–7, before you complete this Report.

A. Net Earned Premium for Standard Health Benefits Plans $ ______

B. Total Losses Incurred (1 - 2 - 3 + 4 + 5 + 6) = $ ______

1. Claims paid during the preceding calendar year regardless of the year incurred; $ ______
2. Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year; ______
3. Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's loss ratio report; ______
4. Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; ______
5. Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year; ______
6. Pro rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20–2.17; [i × (ii ÷ iii)] = ______
   - i. Total net paid loss assessment ______
   - ii. Net earned premium for standard health benefits plans ______
   - iii. Net earned premiums for all health benefits plans ______

C. Loss Ratio (B ÷ A) = ____% (if less than 75%, fill out D and E below)

D. Amount entered on line B ÷ .75 = ______

E. Amount to be refunded to policy or contract holders (A-D) = ______

If the amount entered on line C is less than 75%, you must attach to this Report a refund plan that conforms with N.J.A.C. 11:20–7.5. Please submit this form and a refund plan to the address listed in N.J.A.C. 11:20–2.1(h).

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 17B:27A–9e(1) and (2) and N.J.A.C. 11:20–7.

____
Actuary's Signature

____
Actuary's Name (Please print clearly)

____
Title Date

____
Telephone Number

Amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

EXHIBIT K

New Jersey Individual Health Coverage Program

Carrier Market Share and Net Paid Loss Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. In 1993, Reports must be completed and returned on or before June 28, 1993. Thereafter, Reports must be completed and returned on or before March 1 annually. Completed Reports must be returned to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Part A. Carrier Information

1. Carrier's Name: ______
2. Carrier's NAIC Number (including Group): ______
3. Is the specifically-named Carrier an affiliated Carrier?
   ____Yes ____No.
   a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically-named Carrier?
      ____All Affiliated Carriers' combined Report
      ____Specifically-named Carrier's separate Report
   b. If for all Affiliated Carriers, indicate the number of specifically-named Carrier Reports attached to this combined Report. ______

Part B. Personal Respondent Information

1. Name: ______
2. Title: ______
3. Telephone No: ______ Facsimile No: ______

Part C. Calendar Year Information for ______ (year)

1. Net earned premium for all group and individual health benefits plans: $______
2. Number of non-group persons enrolled by the Carrier:
   a. Community rated and modified community rated persons ______
   b. Community rated conversion policy persons ______
   c. Medicare cost and risk persons ______
   d. Medicaid recipients ______
   e. HealthStart Plus recipients ______
   Non-group Total ______
3. Net paid loss report for Individual Health Benefits Plans:
   a. PREMIUM EARNED
      Community rated and modified community rated $
   b. CLAIMS PAID (-)
      Community rated and modified community rated $
   c. EXPENSES (-)
      Community rated and modified community rated $
   d. SUBSIDIES (+)
      (BCBSNJ only; 1992 only)
   e. NET INVESTMENT INCOME (+)
      Community rated and modified community rated $
   f. NET PAID GAIN/(LOSS)
      Community rated and modified community rated $______
   g. REIMBURSEMENT SOUGHT $______
      (For 1992: Limited to the Lesser of $10,000,000 or 50% of the Net Paid Loss)

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provision of N.J.A.C. 11:20–8.

______ ______ ______
Signature Title Date

EXHIBIT L

Carrier Name ______________________ Name of Person Completing Report ______________________

Telephone Number ______________________

Quarter Ending ____________ Fax Number ______________________

Enrollment Status Report

Quarterly Statistics

Open Enrolled, Community Rated Individual Plans

Health Benefits Plan	Issued Prior to August 1, 1993	Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A. Report by Subscriber Contract													
I. Number of Contracts Inforce Beginning of Period													
II. New Sales and Conversions Issued in Period													
Total Number of New Contracts													
Contracts by Employment Status													
Number Employed													
Number Unemployed													
Number Unknown													
Contracts by Replacement Status													
Number Previously Insured													
Number Previously Uninsured													
Number Unknown													
III. Number of Contract Lapses in Period													
IV. Number of Contracts Inforce End of Period (I. + II. - III.)													
B. Report by Persons Insured (End of Period)													
I. Number Insured Beginning of Period													
II. Number of New Insureds During Period													
III. Number of Insureds Lapsed During Period													
IV. Number Insured End of Period (I. + II. - III.)													
C. Report of Contracts by Rating Category (End of Period)													
Number of Single Subscriber Contracts													
Number of Husband and Wife Subscriber Contracts													
Number of Parent and Child(ren) Contracts													
Number of Family Contracts													
D. Report of Contracts by Deductible/Copayment Option (End of Per.)													
Number of Subscriber Contracts with $150 or $250 Deduct or $10 Copay													
Number of Subscriber Contracts with $500 Deduct or $15 Copay													
Number of Subscriber Contracts with $1000 Deduct or $20 Copay													

Part 2

Annual Report Page 1

Carrier Name ______________________ Name of Person Completing Report ______________________

Telephone Number ______________________

Year Ending ____________ Fax Number ______________________

Enrollment Status Report

Annual Statistics

Open Enrolled, Community Rated Individual Plans

Health Benefits Plan		Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A Report of Contracts by Zip Code Categories													
Number of Subscriber Contracts in Zip Code Areas 070 073													
Zip Code Areas 074 075													
Zip Code Areas 076													
Zip Code Areas 077													
Zip Code Areas 078													
Zip Code Areas 079													
Zip Code Areas 080 084													
Zip Code Areas 085													
Zip Code Areas 086													
Zip Code Areas 087													
Zip Code Areas 088 089													
Total Subscribers													
B Report of Covered Persons by Age and Sex													
Number of Male Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Number of Female Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Total Covered Persons End of Period													

Annual Report Page 2

C. Report of Salary Data														
Number of Subscriber Contracts														
Salary Under $10,000														
$10 to $20,000														
$20 to $30,000														
$30 to $40,000														
$40 to $50,000														
$50 to $60,000														
$60,000 & Over														
Total Subscribers														

New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

EXHIBIT M

PPO STANDARD PLAN PROVISIONS

[III. PREFERRED PROVIDER ORGANIZATION PROVISIONS

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. [In addition to an identification card,] the Covered Person will periodically be given up-to-date lists of [XYZ Health Care] Network Providers.

Use of the network is strictly voluntary, but We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if a[n] [XYZ Health Care] Network Provider orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider or Facility. And, he or she is free to change Providers or Facilities at any time.

A Covered Person may use any [XYZ Health Care] Network Provider. [He or she just presents his or her XYZ Health Care Network identification card to the XYZ Health Care Network Provider or Facility furnishing covered services or supplies. Most XYZ Health Care Network Providers and Facilities will prepare any necessary claim forms for him or her, and submit the forms to Carrier.] The Covered Person will receive an explanation of any insurance payments made by this Policy. [And if there is any balance due, the [XYZ Health Care] Network Provider or Facility will bill You.]

This Policy also has utilization review features. See the "Utilization Review" section for details.

What We pay is subject to all the terms of this Policy. You should read this policy carefully and keep it available when consulting a Provider.

See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You should call Us [Claim Office at the number shown on your identification card.]

GRIEVANCE PROCEDURE

[Carrier is required to include a Grievance Procedure. The text of the Grievance Procedure must be consistent with that which has been the filing of the Carrier's Selective Contracting Arrangement filing, as required by N.J.A.C. 11:4–37 or approved by the appropriate regulatory authority of the State of New Jersey.]

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

EXHIBIT N

POS STANDARD PLAN PROVISIONS

[III. POINT OF SERVICE PROVISIONS

A. Definitions

Primary Care Physician (PCP) means the Physician the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. We will supply a list of [PCPs] who are members of the [XYZ] Provider Organization to You.

Provider Organization (PO) means a network of health care Providers located in a Covered Person's Service Area.

In-Network Benefits means the benefits shown in the Schedule which are provided if the [Primary Care Practitioner] provides care, treatment, services, or supplies to the Covered Person or if the [Primary Care Practitioner] refers the Covered Person to another Provider for such care, treatment, services, or supplies.

Out-of-Network Benefits means the benefits shown in the Schedule of Benefits which are provided in the [Primary Care Practitioner] does not authorize the care, treatment, services, and supplies.

Service Area means the geographical area which is served by the Practitioner in the [XYZ] Provider Organization.

B. Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This policy requires that the Covered Person uses the services of a [PCP], or be referred for services by a [PCP], in order to receive Network Benefits.

C. The [Primary Care Physician (PCP)]

The [PCP] will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The [PCP] must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral form from his or her [PCP] before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-of-Network Benefits.

We provide In-Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her [PCP]. We pay Out-of-Network Benefits when covered services and supplies are not authorized by the [PCP]. If services or supplies are obtained from [XYZ] Providers but they are not authorized by the [PCP], the Covered Person may only be eligible for Out-of-Network Benefits.

A Covered Person may change his or her [PCP] to another [PCP] [once a month]. He or she may select another [PCP] from the list of Practitioner's and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a [PCP], he or she must present his or her ID card and pay the Copayment. When a Covered Person's [PCP] refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us. [PCP]

**[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her [PCP]. She must obtain authorization from her [PCP] for any services beyond a routine exam and tests.]

**[A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.]

****NOTE TO CARRIERS: If you elect to provide self-referral coverage for gynecological care please choose one of the items identified with ** to include in your New Jersey Individual Health Coverage Plans.**

D. Out-of-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her [PCP], he or she will not be eligible for the In-Network Level of Benefits. For services which have not been referred by the Covered Person's [PCP], whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-of-Network Benefits.

E. Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her [PCP or Us] within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed [by the [PCP]]. We will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the [PCP or We] must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

F. Utilization Review

This Policy has utilization review features. See the "Utilization Review" section of this Policy.

G. Benefits

The "Schedule of Benefits" shows Network Benefits, Out-of-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What We pay is subject to all the terms of this Policy.]

For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within hours prior to the reapproved discharge date for additional authorization.

GRIEVANCE PROCEDURE

[Carrier is required to include a Grievance Procedure. If a Carrier has had a Selective Contracting Arrangement approved by the New Jersey Departments of Insurance and Health, it must include that approved Grievance Procedure language in the standard IHC forms.]

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

EXHIBIT O

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan
A when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/Network Provider/Care Manager] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] [Care Manager] [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM UNLESS OTHERWISE STATED.

FACILITY BENEFIT—30 days Inpatient Hospital care.
In-Network [ ]
Out-of-Network [ ]

COINSURANCE:
FACILITY
In-Network [ ]
Out-of-Network [ ]
PRACTITIONER'S SERVICES
In-Network [ ]
Out-of-Network [ ]

NOTE: The Coinsurance Amounts cannot be met with:
- Non-Covered Expenses
- Cash Deductibles
- Copayments

CASH DEDUCTIBLES:
INPATIENT (separate)—$250/day, $1,250 per Period of Confinement/Covered Person; max. of two Inpatient Deductibles/Covered Person.
In-Network [ ]
Out-of-Network [ ]
OTHER COVERED CHARGES—$250/Covered Person, $500/family.
In-Network [ ]
Out-of-Network [ ]

PRIMARY CARE SERVICES—$100/Covered Person, $300/family.
Not subject to Deductibles and Coinsurance.
In-Network [ ]
Out-of-Network [ ]

[OTHER—LIST]
In-Network [ ]
Out-of-Network [ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

EXHIBIT P

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan B through E when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/Network Provider/Care Manager] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] [Care Manager] [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO [AN UNLIMITED (PLANS C-E)] [$1,000,000 (PLAN B)] PER LIFETIME MAXIMUM UNLESS OTHERWISE STATED.

FACILITY BENEFIT—365 days Inpatient Hospital care.
In-Network [ ]
Out-of-Network [ ]

COINSURANCE:
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE
In-Network [ ]
Out-of-Network [ ]
OTHER COVERED CHARGES
In-Network [ ]
Out-of-Network [ ]

COINSURANCE CAP—[Insert Appropriate Plan Amounts per Covered Person and per Family]

NOTE: The Coinsurance Caps cannot be met with:
- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[Insert Appropriate Plan Amounts/Covered Person]
[Insert Appropriate Plan Amounts/family]

EMERGENCY ROOM COPAYMENT (Credited toward Inpatient admission if admission occurs within 24 hours as the result of the Medical Emergency)
In-Network [ ]
Out-of-Network [ ]

HOME HEALTH CARE—Unlimited days, if preapproved.
In-Network [ ]
Out-of-Network [ ]

HOSPICE CARE—Unlimited days, if preapproved.
In-Network [ ]
Out-of-Network [ ]

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—Up to $5,000/Benefit Period combined Inpatient and Outpatient.
BENEFIT MAXIMUMS—Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.
In-Network [ ]
Out-of-Network [ ]

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.
In-Network [ ]
Out-of-Network [ ]

PRIMARY CARE SERVICES
In-Network [ ]
Out-of-Network [ ]

SKILLED NURSING CARE
In-Network [ ]
Out-of-Network [ ]

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.
In-Network [ ]
Out-of-Network [ ]

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).
In-Network [ ]
Out-of-Network [ ]

[OTHER—LIST]
In-Network [ ]
Out-of-Network [ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

EXHIBIT Q

CERTIFICATION OF COMPLIANCE

Submit this form in triplicate to the IHC Board at the following address: 20 West State Street, CN–325, Trenton, New Jersey 08625. Affiliated Carriers must file separate forms.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: ____________________

NAIC#: ____________________

Respondent's Name: ____________________

Respondent's Title: ____________________

Respondent's Address: ____________________

Respondent's Address: ____________________

Respondent's Telephone __________ FAX: __________

2. COMPLIANCE

Check all appropriate responses.

_______ (a) We are using the following forms which fully comply with the IHC Board's individual health benefits plan forms as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

_______ Plan A/Exhibit A
_______ Plan B/Exhibit B
_______ Plan C/Exhibit C
_______ Plan D/Exhibit D
_______ Plan E/Exhibit E
_______ HMO Plan/Exhibit F

_______ (b) Our application form complies with the IHC Board's form as set forth in Exhibit G in the Appendix to N.J.A.C. 11:20.

_______ (c) We are using an alternative application form pursuant to N.J.A.C. 11:20-4.1(b) and three copies of said form are hereby being submitted to the IHC Board for approval.

3. PLAN OPTIONS

Complete each relevant section (please use "NA" to indicate when a section is not relevant). Attach additional pages as necessary.

(a) Plans A through E

(1) List all plans to be offered as traditional indemnity contracts, if any.

____
____
____

(2) List all plans to be offered in conjunction with a selective contracting arrangement (defined as N.J.A.C. 11:4–37), if any.

____
____
____

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the coinsurance differentials and whether the plan requires election of a primary care physician.

____

____

____

(4) Do the plans provide for direct payment to health care practitioners without assignment? (Note: this option is available only on health service corporation plans and other plans offered in conjunction with selective contracting arrangements.)

___ Yes ___ No

(5) Do the plans include any of the following as set forth by the IHC Board?

i. Alternate Treatment Features
_______ Yes _______ No

ii. Centers of Excellence Features
_______ Yes _______ No

(b) HMO Plan

(1) Check the copayment options being offered.
☐ $10 (Optional)
☐ $15 (Standard)
☐ $20 (Optional)

(2) Is the in-network prescription drug coverage being offered?
☐ $15 Copayment
☐ 50% Co-insurance

4. CERTIFICATION

I, the undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

_____________ _________________________
Date Signature

____
Title

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Administrative Change.
See: 27 N.J.R. 1423(a).

EXHIBIT R

[Carrier]

MANDATED OFFER RIDER

[Policyholder]

[Policy No.]

Effective Date:

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in Plans B-E:

Item j. of the Transplant Benefits section of the COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is replaced with the following:

j. 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;

k. 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.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in the HMO Plan:

Item 23. of the INPATIENT, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS provision of the COVERED SERVICES AND SUPPLIES section of the Contract is replaced with the following:

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.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plan A should use the following text:

THE COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is expanded to include the following:

Transplants: We cover Medically Necessary and Appropriate Services and Supplies for:

a. 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;

b. 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.

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

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

[Carrier should insert standard amendment closure and signature blocks.]

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT S

[Carrier]

AMENDMENT

[Policyholder]

Effective Date:

[

]

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

[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).