CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

R.2006 d.15 and d.16, effective December 7, 2005.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a);
37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on December 7, 2010.

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Note

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

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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, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

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

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993, except as the specific provisions of 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).
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See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).
Petition for Rulemaking: Exhibits A through F.
See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".

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 16.5).

"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.

"Basic and essential health care services plan" means the health benefits plan pursuant to P.L. 2001, c.368, N.J.S.A. 17B:27A-4.4 through 4.7.

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).

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

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

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

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

formula to cover group conversion excess morbidity costs; or

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

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

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

"Dependent" means the spouse or same-gender domestic partner as that term is defined in P.L. 2003, c. 246 of the applicant, or child of the applicant or domestic partner, subject to applicable terms of the individual health benefits plan.

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

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

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

3. Sits ex officio on the Board of Directors.

"Eligible person" means a person is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.), "Medicare." An eligible person shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.

"Enrollment date" means, with respect to a Federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means the effective date of coverage under the individual health benefit plan.

"Family unit" means a legally married man and woman or person and his or her same-gender domestic partner; a legally married man and woman or person and his or her same-gender domestic partner and their dependent child(ren), as the term dependent is defined in the individual health benefits plan; an adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan, who are members of the same household; and dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

"Federally defined eligible individual" means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months;

2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. §§1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan;

4. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

5. Who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and

6. Who has elected continuation coverage described in 5 above and has exhausted that continuation coverage.

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

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

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1002(32)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

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

and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

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

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year. For purposes of identifying a Federally defined eligible individual, actual and intended presence in the State for a minimum period may not be considered, but a carrier may require an applicant to demonstrate that New Jersey is his or her primary residence as defined by law.

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

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

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

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

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

Amended by R.1994 d.54, effective December 30, 1993.
See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).
Amended by R.1995 d.37, effective December 20, 1994.
See: 27 N.J.R. 41(b), 27 N.J.R. 371(b).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended "Eligible person" and "Family unit".
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2000 d.142, effective March 6, 2000.
See: 32 N.J.R. 643(a), 32 N.J.R. 1253(c).
Rewrote "Member".
Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).
Inserted "Medicare Plus Choice"; in "Net earned premium", inserted reference to Medicare Plus Choice enrollees; and in "Non-group persons", inserted reference to Medicare Plus Choice contract.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Added "Basic and essential health care services plan"; in "Health benefits plan", added new 7, recodified former 7 as 8; in "Non-group persons", inserted "a basic and essential health care services plan pursuant to P.L. 2001, c.368" preceding "Medicare"; deleted "Reimbursement for losses".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "Basic health benefits plan" and "Reasonable and customary"; amended "Dependent", "Director", "Eligible person", "Family unit", "Member", "NAIC", "Net earned premium", "Non-group persons", "Pre-existing condition", and "Resident"; added "Enrollment date", "Federally defined eligible individual", "Medicare Advantage", "NJ FamilyCare", and "NJ KidCare".

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

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

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

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

11:20-1.4 Other laws of this State

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

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Deleted "including individual standard health benefits plans" following "this subchapter".

11:20-1.5 (Reserved)

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

11:20-1.6 Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested persons,

and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to individuals and establishing and administering assessment mechanisms. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

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

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

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

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

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

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

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

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

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

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

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

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

New Jersey Individual Health Coverage Program
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
Telephone: (609)633-1882 x50306
Fax: (609) 633-2030

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), rewrote the introductory paragraph 2; and in (h), updated the address.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Changed subchapter heading from "Individual Health Coverage Program Temporary Plan of Operation". In (c) and (f), deleted references to the Temporary Plan of Operation; rewrote (h).

11:20-2.2 Definitions

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

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

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

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

the dollar amounts of premiums, by subscriber or contract number;

ii. All underwriting and premium records relating to the premiums earned on the data files, including, but not limited to, subscriber applications, billing records, cash receipt and disbursement records, advance premium and premium receivable records and rate filings;

iii. A reconciliation, if necessary, between the total premiums earned per the data files requested in (c)1i above and the premium earned amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iv. A reconciliation, if necessary, between the premiums earned amount reported to the IHC Board on the Exhibit K Assessment Report and premiums earned amount set forth in the Member's Annual Statement Blank filed with the Department or Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

2. With respect to claims paid:

i. Detailed electronic data files of claims paid which, in total, agree to the claims paid reported to the IHC Board on the Exhibit K Assessment Report. The data files shall include sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number. All claim file and disbursement records relating to the claims paid on the data file, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation;

ii. A reconciliation, if necessary, between the total claims paid per the data files requested in (c)2i above and the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iii. A reconciliation, if necessary, between the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report and the claims paid amount set forth in the Member's Annual Statement Blank filed with the Department or the Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

3. With respect to investment income:

i. Detailed schedules of net investment income which, in total, agree to the net investment income reported to the IHC Board on the Exhibit K Assessment Report. The schedules shall set forth the Member's calculation of net investment income allocated to the New Jersey individual line of business and shall include sufficient detail to identify the nature and source of the components used to calculate net investment income; and

ii. All source documentation used in the Member's calculation of net investment income, including, but not limited to, schedules used in the calculation of mean funds by line of business, cash receipt and disbursement records used in the cash flow schedules, and calculations for the Member's investment rate of return.

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

11:20-2.9 Records

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

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

1. Minutes of all Board meetings;

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

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

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

5. The Plan of Operation and any amendments thereto;

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

7. Determinations on requests for exemption by carriers;

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

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

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

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

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

11:20-2.10 Standard health benefits plans

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

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

2. The Policy Forms committee and/or the Board's staff may design or amend the standard health benefits plans, but the Board shall discuss the design and any changes thereto at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

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

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

ii. The Board may establish procedures for a public hearing pursuant to Article III of this Temporary Plan and publish them with the notice of the public hearing.

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

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

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

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

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

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

(b) Members shall submit to the Board, in the care of the Executive Director, a certification, set forth as Exhibit Q in the Appendix to this chapter, that sets forth that the standard policy and application forms will be used in accordance with the requirements of N.J.A.C. 11:20-3.2 and 4.1.

1. No member shall issue a standard health benefits plan until a full schedule of corresponding rates has been filed with the Board in accordance with N.J.A.C. 11:20-6.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.

11:20-2.11 (Reserved)

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

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

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

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

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

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "or the Department" following "of the Board" in the second sentence.

11:20-2.17 (Reserved)

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
The Expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.
See: 37 N.J.R. 2884(a).

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $20.00, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

New Rule, R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) The standard individual health benefits plan established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A;

2. Plan B, "Individual Health Benefits Plan," Exhibit B;

3. Plan C, "Individual Health Benefits Plan C," Exhibit C;

4. Plan D, "Individual Health Benefits Plan D," Exhibit D;

5. Plan E, "Individual Health Benefits Plan E," Exhibit E;

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and

7. Plan A/50, "Basic Health Benefits Plan A/50," Exhibit U.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C and D as set forth in Exhibits U, and B through D, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plan D shall offer the following annual deductible options to the policyholder for each plan:

i. $500.00 per individual and $1,000 per family unit;

ii. $1,000 per individual and $2,000 per family unit;

2. Members offering Plans A/50, B and C shall offer the following annual deductible options to the policyholder for each plan:

i. $1,000 per individual and $2,000 per family unit; and

ii. $2,500 per individual and $5,000 per family unit.

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. $1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, $3,000, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit;

ii. $2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, $4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit.

iii. In the case of single coverage, the greater of: $1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: $2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered family;

iv. In the case of single coverage, $2,000, and in the case of other than single coverage, $4,000;

v. In the case of single coverage, $2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted, per covered person; and in the case of other than single coverage, $5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted.

vi. In the case of single coverage, $5,000, and in the case of other than single coverage, $10,000;

4. Members offering Plan/A50 may offer the following annual deductible options to the policyholder for each plan:

i. $5,000 per individual and $10,000 per family unit; and

ii. $10,000 per individual and $20,000 per family unit.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient copay, $150.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 separate emergency room copay, $25.00 maternity copay, and $15.00 for all other copays. All HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant;

1. $250.00 hospital inpatient copay, $200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 emergency room copay, $25.00 maternity copay, and $20.00 for all other copays; and/or

2. $100.00 hospital inpatient copay, $100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 emergency room copay, $25.00 maternity copay, and $10.00 for all other copays.

3. $300.00 hospital patient copay, $300.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 emergency room copay, $25.00 maternity copay, and $30.00 for all other copays.

(d) Each of the standard health benefits plans, except Plan A/50 and the deductible options listed in (b)3 above, may be offered through or in conjunction with a managed care network, and the standard plans may be offered as a PPO or POS plan by a carrier that is exempt from the requirements of P.L. 1993, c.162, § 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute. These plans should be subject to the following:

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

2. The coinsured charge limit specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits B through D in the Appendix, shall be the maximum amount of covered charges a covered person must incur for the in-network and out-network benefits combined before benefits are paid by the carrier at 100 percent;

3. The HMO Plan copayment levels of $10.00, $15.00, $20.00 and $30.00 may be substituted for deductibles applicable to one or more of the in-network benefits; and

4. The out-network benefit level shall be the coinsurance level of the standard plan. Plan B offered through or in conjunction with a managed care network shall have an out-network coinsurance amount of 60 percent, Plan C shall have an out-network level of 70 percent, and Plan D shall have an out-network level of 80 percent.

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for medical services, based on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or such other state where services or supplies are

provided, for various medical services and supplies, published and available to carriers from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109. Carriers shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

Amended by R.1995 d.531, effective October 2, 1995.
See: 27 N.J.R. 1127(a), 27 N.J.R. 3793(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Inserted new (b)2; recodified former (b)2 as (b)3; and, in (c), inserted reference to (b)2 deductible options.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Substituted Plan B for Plan A as the "The Basic Health Benefits Plan" and amended deductible and copayment amounts.
Amended by R.1998 d.26, effective January 5, 1998.
See: 29 N.J.R. 1089(a), 30 N.J.R. 237(a).
Inserted (d)6.
Administrative correction.
See: 30 N.J.R. 1318(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (a), substituted "Individual" for "Basic" in 2, and added 7; in (b), inserted a reference to Plan A/50, deleted a reference to Plan E, inserted a reference to Exhibit U and substituted a reference to Exhibit D for a reference to Exhibit E in the introductory paragraph, deleted a reference to Plans B and E in the introductory paragraph of 1, and inserted a reference to Plans A/50 and B in the introductory paragraph of 2; in (c), substituted a reference to Plans A/50, B, C, and D for a reference to Plans B through E in the first sentence, and added 3; and in (d), inserted a reference to Plan A/50 in the first sentence, substituted a reference to Exhibit D for a reference to Exhibit E in 2, inserted a reference to $30.00 copayment levels in 3, and deleted ", and Plan E shall have an out-network level of 99 percent" at the end of 4.
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
In (b)3, rewrote i and ii.
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Added (b)4.
Amended by R.2002 d.331, effective October 7, 2002.
See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).
In (b)4, substituted "may" for "shall".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
In (b), added iii through vi in 3.

11:20-3.2 Policy forms

(a) For standard health benefits plans, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F and U, as may be amended by the Board.

(b) A member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall use the appropriate standard language set forth in the Appendix to this subchapter as alternate text in Exhibits B, C and D as described in the Explanation of Brackets, Exhibit T, in conjunction with the standard policy forms set forth as Exhibits B through D.

(c) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification Form set forth in the Appendix to this subchapter as Exhibit Q. Affiliated Carriers must file separate Certification Forms. A new Certification Form must be filed annually on or before March 1.

(d) Carriers that submit an Exhibit Q Certification Form may issue and make effective individual health benefits plans upon filing such forms with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board, following an opportunity for a hearing pursuant to the procedures set forth in N.J.A.C. 11:20-20.2. The Board may disapprove an Exhibit Q Certification filing if the filing is inaccurate or incomplete.

Repeal and New Rule, R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (a), inserted a reference to Exhibit U; and in (b), deleted a reference to Exhibit E, and substituted a reference to Exhibit D for a reference to Exhibit E.

11:20-3.3 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix, incorporated herein by reference, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits A, B, C, D, E and U of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit T, through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix.

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (b), inserted "as described in the Explanation of Brackets, Exhibit T," following "Chapter".
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (b), substituted a reference to Exhibit U for a reference to Exhibit F.

11:20-3.4 Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations and exclusions set forth in N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit V.

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

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

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Inserted "as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368" following the N.J.S.A. references.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Substituted "section" for "sections 2b(1) and" and updated the N.J.S.A. reference.

11:20-6.2 Definitions

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

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

11:20-6.3 Informational rate filing requirements

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

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c.368 and N.J.A.C. 11:20-6.5;

2. Monthly premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate fling, as of the stated effective date. Rates may be developed on different rate tiers for: single; two adults; adult/child(ren); and family; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses the use of the factors of age, gender and geography as discussed in (a)2i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care services plan shall include:

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

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

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

5. A brief statement of reasons for the Board's action.

(c) The Board's action on a petition may include:

1. Denying the petition and providing a written statement of the Board's reasons to the petitioner, and including such reasons in its notice of action;

2. Granting the petition and initiating a rulemaking proceeding within 90 days of the granting of the petition; or

3. Referring the matter for further deliberations which shall be concluded within 90 days of referring the matter for further deliberations. Upon conclusion of such further deliberations, the Board shall either deny the petition and provide a written statement of its reasons or grant the petition and initiate a rulemaking proceeding within 90 days.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), revised the timeframe in which the Board shall respond to a petition for rulemaking from 30 to 60 days; rewrote (c).

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

11:20-20.1 Scope

This subchapter shall apply to all appeals from Board determinations and requests for hearing as expressly provided pursuant to this chapter.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.

11:20-20.2 Appeals procedures

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

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

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

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

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

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are disputed adjudicative facts.

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

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

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

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

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote the introductory paragraph and 1iv; in (a)2, substituted "disputed adjudicative facts" for "material issues of fact in dispute"; in (a)3, substituted "30" for "45" in the introductory paragraph, rewrote i and ii, and added iii.

SUBCHAPTER 21. (RESERVED)

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-22.1 Purpose and scope

(a) This subchapter implements provisions of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.4 through 4.7), an Act that supplements the Individual Health Insurance Reform Act, P.L. 1992, c. 161. This subchapter establishes procedures and standards for carriers to meet their obligations under P.L. 2001, c.368, and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the P.L. 2001, c.368. The other subchapters in this chapter should be consulted for procedures and standards that also have application to the basic and essential health care services plan required by P.L. 2001, c.368.

(b) The provisions of this subchapter shall be applicable to all carriers that are members of the Individual Health

Coverage Program, as the term "member" is defined in N.J.A.C. 11:20-1.2 and N.J.S.A. 17B:27A-2.

(c) The provisions of this subchapter shall be applicable to the marketing, sale, issue and administration of all basic and essential health care services plans.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), in the last sentence, substituted "The" for "Carriers should consult the" and added "should be consulted" following "in this chapter"; in (b), added quotes around the word "member" and changed the N.J.A.C. reference; in (c), deleted "on or after January 1, 2003" at the end of the paragraph.

11:20-22.2 Definitions

Words and terms contained in N.J.S.A. 17B:27A-2 et seq., when used in this chapter, shall have the meanings as defined in the N.J.S.A. 17B:27A-2 et seq., and N.J.A.C. 11:20-1.2 unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter, as follows:

"Copayment" means a specified dollar amount which a person covered under a basic and essential health care services plan must pay for certain charges covered under such plan. A covered person may be required to pay an amount in excess of the copayment if the charge the provider bills exceeds the reasonable and customary charge.

"Good faith effort" means the demonstrated efforts a carrier undertakes to make the basic and essential health care services plan available to residents of New Jersey, as evaluated by the Board pursuant to the standards set forth in this subchapter.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, except that a rate differential may be applied on the basis of age, gender and geography, as detailed in section 2.c of P.L. 2001, c.368, and in this subchapter.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In the introductory paragraph, updated the N.J.A.C. reference.

11:20-22.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan.

(b) Members that write individual health benefits plans as HMO coverage and as indemnity coverage may choose to offer the basic and essential health care services plan as an HMO plan or as an indemnity plan and are not required to write the plan as both an HMO plan and as an indemnity plan. Carriers that choose to offer the basic and essential health care services plan as an indemnity plan may include provisions to create an indemnity-based preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.

11:20-22.4 Filing the basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care service plan policy form, the member shall submit the information set forth below to the Board at the address specified at N.J.A.C. 11:20-2.1(h):

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

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

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

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

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

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

1. Members that choose to use the plan specimen policy form as set forth in Exhibit V shall submit, in lieu of a copy of the basic and essential health care services plan policy form, a Certification, signed by a duly authorized officer of the company, stating that the Company is using the basic and essential health care services plan specimen policy form as included in Exhibit V, including the carrier name, and similar variable text, as appropriate. The Certification regarding use of the specimen policy form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

2. Members that choose to use the plan specimen policy form as set forth in Exhibit V with some modifications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit V. The redlined text of the form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

(c) The Board shall notify a member in writing of its determination whether the policy form filing is approved within 30 days of the date the filing is received. If the Board

does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval. The member shall submit:

1. A copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20- 2.1(h);

2. A copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change;

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

i. The member shall make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

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

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D "Covered Charges" or "Charges Covered with Special Limitations" sections of the policy or set forth in the standard HMO "Covered Services and Supplies" section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board's rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier's standard A/50 through D plan or standard HMO plan, as applicable.

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

(d) A member seeking to challenge the Board's disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later 60 days following the close of each calendar quarter:

1. For standard indemnity plans, standard PPO plans, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total in force) reporting both number of contracts and number of lives as of the last day of the calendar quarter; and

2. For basic and essential health care services plans issued during the calendar quarter with a rider, the carrier shall submit:

i. The number of persons enrolled who were previously uninsured; and

ii. For all persons previously insured, the numbers of persons whose prior source of coverage was group; COBRA/state continuation; standard IHC plan; unridered basic and essential health care services plans plan, or other basic and essential health care services plans with rider.

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year:

1. For standard indemnity plans, standard PPO plans, standard HMO plans, basic and essential health care services plans, plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b)1, substituted "A" for "One"; in (b)3, added iv-vi; added (b)4; added (d)-(i).

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan.

(b) The report shall include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier provides a certification in which it certifies that it either did or did not use any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (c)1ii, deleted "may" in the second sentence; in (c)1iii, substituted "provides a certification in which it certifies that it either did or did not use any" for "certifies whether it used any".

11:20-22.7 Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S.A. 17B:30-1.

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1 Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C. 11:20-23.6 is to establish procedures for public notice

APPENDIX
EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board 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. 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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GENERAL PROVISIONS

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 [__].

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.

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.

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

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include the Cash Deductible, 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" 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 Preventive Care;

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.

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

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

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) 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 support himself or herself;
(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 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 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 Preventive Care provision of the COVERED CHARGES 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 /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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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.

EXPERIMENTAL or INVESTIGATIONAL. Continued)

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.

EXPERIMENTAL or INVESTIGATIONAL. Continued)

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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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.

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

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

coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose 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 he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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-rays 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.

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 for its stated purpose by the state in which it operates.

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

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

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

SKILLED NURSING 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 for its stated purpose 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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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 the 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 You are an Eligible Person, except as provided below.
(b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
(c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except:** a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..

(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.

SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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	$5,000 per 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
- The Cash Deductible
- 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 Calendar Year	$2500	
CASH DEDUCTIBLE PER CALENDAR YEAR		
for Hospital Confinement	NONE	(Note: See Hospital Inpatient Copayment)
for Preventive Care	NONE	
for immunizations and lead screening for children		NONE
for all other Covered Charges		
per Covered Person		$250
per Covered Family		$500

PREVENTIVE CARE $100 / Covered Person, $300 / family. Primary Care Services are not subject to the Deductible and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED OR 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.

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 "Premiums 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.

BENEFIT DEDUCTIBLE, COPAYMENT AND COINSURANCE

Cash Deductible: Each Calendar Year, 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 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 Calendar Year. 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 Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 Hospital Inpatient Copayment for each day of confinement, up to a maximum of $1250 per Covered Person per Period of Confinement, up to a maximum $2500 Hospital Inpatient Copayment per Covered Person per Calendar Year.

Coinsurance Cap: This Policy limits the Facility Coinsurance amounts You must pay each Calendar Year. 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 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year for the Facility benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Calendar Year.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Calendar Year starts under this Policy, provided 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 Deductible or Coinsurance into the next Calendar Year. 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 Calendar Year, 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.

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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; 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;
(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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured. 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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

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.**

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

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

Practitioner Charges for Nonsurgical Care and Treatment: We only cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury under Preventive Care. See the "Schedule of Benefits" and "Preventive Care" 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 cost 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 Calendar Year. 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, a 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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.

EXCEPTION: The Pre-Existing Conditions Limitation does not apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will credit the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

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

These charges are not subject to the 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned Children; and
(b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

These charges are not subject to 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 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.]

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 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 are 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
Knee Replacement

Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
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 acknowledgment 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)**, or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function

h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) 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.]

[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.]]

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.

Dialysis treatment.

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

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 Preventive Care.

Non-Prescription Drugs or supplies, except:
a) insulin, needles and syringes; and
b) as stated in this Policy for food and food products for inherited metabolic diseases.

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, except as stated in this Policy.

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 or 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 and Medicare.) 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 his or her 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.

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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)

d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

TERMINATION OF DEPENDENT COVERAGE

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

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

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.

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.

[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.]

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, he or she may apply for his or her 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 due. Our sole liability is as set forth above.]

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 the requirements of that law.

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).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

EXHIBIT B

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 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 B 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. 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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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 [____].

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

ALCOHOLISM. Abuse of or addiction to alcohol and does **not** include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

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

BIRTHING CENTER. 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.

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

COINSURANCE. The percentage of 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 Preventive Care;
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.

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

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

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) 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 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 Preventive Care provision of the COVERED CHARGES 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 / 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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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) roof 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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.

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

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

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, including Substance Abuse, regardless of any underlying physical cause. As used in this Policy, a Mental or Nervous Condition does not include a Biologically-based Mental Disorder, or Alcoholism, as defined in this Policy.

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

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

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 NETWORK PROVIDER.** A Provider which is not a 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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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-rays 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.

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 for its stated purpose by the state in which it operates.

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

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 for its stated purpose 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 but does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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 You are an Eligible Person, except as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except:** a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident.

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.].

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.

[SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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 $3000/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 PER CALENDAR YEAR
•for Preventive Care NONE
•for immunizations and lead screening for children NONE
•for all other Covered Charges
per Covered Person [$250, $500, $1000, $2500]
per Covered Family [$500, $1000, $2000, $5000]

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

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $300/Covered Person)
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 Calendar Year
•Occupational Therapy 30 visits per Covered Person per Calendar Year
•Speech Therapy 30 visits per Covered Person per Calendar Year
•Cognitive RehabilitationTherapy 30 visits per Covered Person per Calendar Year
Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS SAMPLE PPO (without Copayment)

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:

•if treatment, services or supplies are given by a Network Provider	[10%]
•if treatment, services or supplies are given by an Out-Network Provider	40%

COINSURED CHARGE LIMIT

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

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

Coinsured Charge Limit: $10,000 per Covered Person

CASH DEDUCTIBLE PER CALENDAR YEAR

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000, $2500]
per Covered Family	[$1000, $2000, $5000]

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

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

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 "Premiums 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 for 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:
•by amendment of the Policy; or
•by reason of any provision of law or any government program or regulation;
c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

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

[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] preferred 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] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider, and he or she is free to change Providers at any time.

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

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Provider will bill him or her directly.

This Policy also has utilization review provisions. 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 may contact Our [Claim Office at the number shown on Your identification card.]

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals procedure when the plans are issued including Preferred Provider Organization or Point of Service provisions. If a carrier has had a Selective Contracting Arrangement approved by the New Jersey Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 per Period of Confinement, up to a maximum $2000 Hospital Inpatient Copayment per Covered Person per Calendar Year. **NOTE:** This Hospital Inpatient Copayment is **in addition** to the Cash Deductible.

[**Coinsurance Cap:** This Policy limits the Coinsurance amounts You must pay each Calendar Year. 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year.]

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

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

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

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

NOTE: There is no Coinsurance credit from previous coverage.

Hospital Inpatient 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 Calendar Year 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 Calendar Year into a succeeding Calendar Year. **Note:** There is never a carryover of Deductible or Coinsurance from one Calendar Year into a succeeding Calendar Year.

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

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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 Hospital Inpatient Copayment.

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.

Biologically-based Mental Illness: We pay benefits for the treatment of a Biologically-based Mental Illness 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.

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:
1) ordered by Your Practitioner;
2) 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. 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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured. 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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

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.**

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

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

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. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of this Policy.

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 Calendar Year, 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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.

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) a medical condition covered by this Policy which requires Hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

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 is not a Biologically–based Mental Illness, as defined in this Policy, and 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 Calendar Year. 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.

EXCEPTION: The Pre-Existing Conditions Limitation does not apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will credit the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis.

Preventive Care: 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 Preventive Care. 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and

b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

These charges are not subject to 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 Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Policy.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year 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 Calendar Year. 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) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated 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.]

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.

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 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 are 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	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy Tubal	Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

MEDICAL PROCEDURES	DIAGNOSTIC PROCEDURES
Lower Back Medical Care	Cardiac Catheterization
	CAT SCAN
	Cystoscopy
	Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care	Hospice Care
Skilled Nursing Care	Infusion Therapy
Maternity Care (See STEP 2(a))	

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 acknowledgment 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)**, or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by 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.

[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.]]

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.

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

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

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

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, except as stated in this Policy.

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 or 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:

a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) 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 (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) 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.

Vision therapy, vision or 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.

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 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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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 for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

TERMINATION OF DEPENDENT COVERAGE

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

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

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

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.

[NETWORK AND OUT -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.

A 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 Network Provider may be different than Our Network Provider Allowance; also, an Out 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.

[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.]

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her 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.]

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 the requirements of that law.

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).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).

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]
INDIVIDUAL HEALTH BENEFITS PLAN C
(New Jersey Individual Health Benefits C 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. 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.

[Dividends are apportioned each year.]

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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 [___].

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

ALCOHOLISM. Abuse of or addiction to alcohol. Alcoholism does **not** include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

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.

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

BIRTHING CENTER. 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.

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

COINSURANCE. The percentage of 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 Preventive Care;
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.

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

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

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) 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 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 Preventive Care provision of the COVERED CHARGES 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/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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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

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

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

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

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose by the state in which it operates.

[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.]

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-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

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

NON-COVERED 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 NETWORK PROVIDER.** A Provider which is not a 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 Non-Biologically-based Mental Illnesses 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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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.

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 for its stated purpose by the state in which it operates.

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

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 for its stated purpose 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 does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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 You are an Eligible Person, **except** as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person, **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except:** a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid[.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..
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.

[SCHEDULE OF BENEFITS [non-[MSA]/high-deductible health plan text – not appropriate for use in conjunction with an MSA or an HSA]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•Non-Biologically-based Mental Illnesses and Substance Abuse	30%
•Other Covered Charges -	30%
COINSURANCE CAP	After $2500/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 Non-Biologically-based Mental Illnesses and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$250, $500, $1000 or $2500]
per Covered Family	[$500, $1000, $2000 or $5000]
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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[[SCHEDULE OF BENEFITS **[[MSA]high-deductible health plan text – could be used in conjunction with an MSA or an HSA]**

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

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

FACILITY BENEFIT	365 days Inpaticnt Hospital care.
COINSURANCE:	30%
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
Note to carriers: Use the following text for MSA plans	
•for all other Covered Charges	
[per Covered Person	[$1,500][$2,250]][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[1550, $2300]]
per Covered Family	[$3,000][$4,500[Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[3050, $4600]
Note to carriers: Use the following text for HSA plans	
•for all other Covered Charges	
[per Covered Person	[the greater of: $1,200 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$2,000] [$2,800 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$5,000]]
[per Covered Family	[the greater of: $2,400 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$4,000] [$5,600 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$10,000]]
For all other Covered Charges	
[per Covered Person	
Note to carriers: Use the following text for MSA plans	
OUT OF POCKET MAXIMUM	
per Covered Person	[$3,000][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[3050].]
per Covered Family	[$5,500][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[5600].]
Note to carriers: Use the following text for HSA plans	
OUT OF POCKET MAXIMUM	
[per Covered Person	[the greater of $5,100 or the maximum amount permitted under Internal Revenue Code 223]]
[per Covered Family	[the greater of $10,200 or the maximum amount permitted under Internal Revenue Code 223]]

Note: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	30%

COINSURED CHARGE LIMIT

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

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given by a Network Provider	
•[Physician Visits	$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]

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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	30%

COINSURED CHARGE LIMIT

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

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE

•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]
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.

NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE

BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given or referred by the PCP	[NONE]
•if treatment, services or supplies are given by non-referred Provider	30%

COINSURED CHARGE LIMIT

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

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given or referred by the PCP	
•Physician Visits	[$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by a non-referred Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]
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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

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 "Premiums 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 for 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:
•by amendment of the Policy; or
•by reason of any provision of law or any government program or regulation;
c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

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

[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] preferred 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] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider, and he or she is free to change Providers at any time.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ Health Care Network] Provider or a non-[XYZ Health Care Network] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ Health Care Network] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] Provider.

However, follow-up care or treatment by a non-[XYZ Health Care Network] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] Service Area.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Provider will bill him or her directly.

This Policy also has utilization review provisions. 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 may contact Our [Claim Office at the number shown on Your identification card.]

[POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ Provider Organization.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule of Benefits which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d) ***Out-Network Benefits*** mean the benefits shown in the Schedule of benefits which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ Provider Organization.]

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ Provider Organization]. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ PO.] The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Provider when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay Out-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-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ PO] by [phone or in writing].

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

[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.]

[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.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. 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-Network Benefits.

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 within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

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

Utilization Review
This Policy has utilization provisions. See the **Utilization Review** section of this Policy.

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

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals procedure when the plans are issued including Preferred Provider Organization or Point of Service provisions. If a carrier has had a Selective Contracting Arrangement approved by the New Jersey Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [non [MSA] text – not appropriate for in conjunction with an MSA or an HSA]

Cash Deductible: Each Calendar Year, 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Non-Biologically-based Mental Illnesses 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year.]

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

Exception: Charges for Non-Biologically-based Mental Illnesses, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.]**

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

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

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

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

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [[MSA] text – could be used in conjunction with an MSA or and HSA]

Cash Deductible: Each Calendar Year, 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 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Calendar Year. 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 Calendar Year. 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 Calendar Year. Once the Per Covered Person Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family must pay during each Calendar Year. Once the Per Covered Family Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Calendar Year.

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

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

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

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

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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.

Biologically-based Mental Illness: We pay benefits for the treatment of a Biologically-based Mental Illness 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.

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:
    1) ordered by Your Practitioner;
    2) 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. 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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured. 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.

Note to carriers: Use the following text for plans not issued in conjunction with an MSA or HSA
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.

Note to carriers: Use the following text for plans issued in conjunction with an MSA or HSA
We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment.

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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

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.**

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

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

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. Except as stated in the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy, We do not cover drugs to treat Non-Biologically-based Mental Illnesses and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy.

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 Calendar Year, 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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.

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Non-Biologically-based Mental Illness and Substance Abuse: We limit what We pay for the treatment of Non-Biologically-based Mental Illness and Substance Abuse as those terms are defined in this Policy.

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 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 Calendar Year. 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.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: 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 Preventive Care. 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

These charges are not subject to 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 Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Policy.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year 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 Calendar Year. 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) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated 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.]

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.

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 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 are 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
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy

Gastroduodenoscopy
Hip Replacement
Hysterectomy
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 acknowledgment 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),** or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by 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.

[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.]]

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.

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

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

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non-Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets; **{and}**
b) colostomy bags, belts, and irrigators**{.}**; **and**
c) **as stated in this Policy for food and food products for inherited metabolic diseases.**

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, except as stated in this Policy.

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 or 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:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) 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 (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) 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.

Vision therapy, vision or 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.

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 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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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 for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give you at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

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

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.

[NETWORK AND OUT 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.

A 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 Network Provider may be different than Our Network Provider Allowance; also, an Out 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.

[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, he or she may apply for his or her 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.]

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 the requirements of that law.

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.
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).

APPENDIX 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 D 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. 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.

[Dividends are apportioned each year.]

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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 [__].

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

ALCOHOLISM. Abuse of or addiction to alcohol. Alcoholism does **not** include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

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.

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

BIRTHING CENTER. 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.

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

COINSURANCE. The percentage of 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 Preventive Care;
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.

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

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

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) 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 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 Preventive Care provision of the COVERED CHARGES 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 /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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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.

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

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

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose by the state in which it operates.

[**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]

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-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

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

NON-COVERED 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-NETWORK PROVIDER.** A Provider which is not a 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 Non-Biologically-based Mental Illnesses 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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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-rays 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.

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 for its stated purpose by the state in which it operates.

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

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 for its stated purpose 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 does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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 You are an Eligible Person, **except** as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person, **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy, **except:** a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident.

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid[.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.].
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.

[SCHEDULE OF BENEFITS [non- **[MSA]/high-deductible health plan text – not appropriate for use in conjunction with and MSA or an HSA]**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•Non-Biologically-based Mental Illnesses and Substance Abuse	25%
•Other Covered Charges -	20%
COINSURANCE CAP	After $2000/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 Non-Biologically-based Mental Illnesses and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	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	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS [[MSA] text – high deductible health plan text - could be used in conjunction with an MSA or an HSA]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•Non-Biologically-based Mental Illnesses and Substance Abuse	25%
•Other Covered Charges -	20%
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
Note to carriers: Use the following text for MSA plans	
•for all other Covered Charges	
[per Covered Person	[$1,500][$2,250]][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[1550, $2300]]
per Covered Family	[$3,000][$4,500[Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[3050, $4600]
Note to carriers: Use the following text for HSA plans	
•for all other Covered Charges	
[per Covered Person	[the greater of: $1,200 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$2,000] [$2,800 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$5,000]]
[per Covered Family	[the greater of: $2,400 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$4,000] [$5,600 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$10,000]]
For all other Covered Charges	
[per Covered Person	
Note to carriers: Use the following text for MSA plans	
OUT OF POCKET MAXIMUM	
per Covered Person	[$3,000][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[3050].]
per Covered Family	[$5,500][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[5600].]
Note to carriers: Use the following text for HSA plans	
OUT OF POCKET MAXIMUM	
[per Covered Person	**[the greater of $5,100 or the maximum amount permitted under Internal Revenue Code 223]]**
[per Covered Family	**[the greater of $10,200 or the maximum amount permitted under Internal Revenue Code 223]]**

Note: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	20%, **except** as stated below
Exception: For Non-Biologically-based Mental Illnesses and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT

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

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given by a Network Provider	
•[Physician Visits	$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
[Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE

•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	20%, **except** as stated below
Exception: For Non-Biologically-based Mental Illnesses and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%
COINSURED CHARGE LIMIT	

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

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
•if treatment, services or supplies are given or referred by the PCP	[NONE]

•if treatment, services or supplies are given by non-referred Provider	20%, **except** as stated below
Exception: For Non-Biologically-based Mental Illnesses and Substance Abuse charges if treatment, services or supplies are given by non-referred Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person must incur each Calendar Year before no Coinsurance is required, **except** as stated below.

Exception: Charges for Non-Biologically-based Mental Illnesses and Substance Abuse treatment are not subject to or eligible for the Coinsured Charge Limit.

Coinsured Charge Limit:	$10,000 per Covered Person

COPAYMENT

If treatment, services or supplies are given or referred by the PCP	
•Physician Visits	[$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]

CASH DEDUCTIBLE PER CALENDAR YEAR

If treatment, services or supplies are given by a non-referred Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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.
NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person) 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 Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

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 "Premiums 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 for 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:
•by amendment of the Policy; or
•by reason of any provision of law or any government program or regulation;
c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

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

[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] preferred 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] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider, and he or she is free to change Providers at any time.

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

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Provider will bill him or her directly.

This Policy also has utilization review provisions. 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 may contact Our [Claim Office at the number shown on Your identification card.]

[POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ Provider Organization.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule of Benefits which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d) ***Out-Network Benefits*** mean the benefits shown in the Schedule of benefits which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ Provider Organization.]

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ Provider Organization]. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ PO.] The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Provider when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay Out-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-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ PO] by [phone or in writing].

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

[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.]

[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.]

Out-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. 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-Network Benefits.

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 within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

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

Utilization Review
This Policy has utilization provisions. See the **Utilization Review** section of this Policy.

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

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals procedure when the plans are issued including Preferred Provider Organization or Point of Service provisions. If a carrier has had a Selective Contracting Arrangement approved by the New Jersey Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [non [MSA]**high-deductible health plan text – not appropriate for use in conjunction with an MSA or an HSA]**

Cash Deductible: Each Calendar Year, 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Non-Biologically-based Mental Illnesses 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year.]

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

Exception: Charges for Non-Biologically-based Mental Illnesses, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.]**

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

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

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

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

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [[MSA]high-deductible health plan text – could be used in conjunction with an MSA or an HSA]
Cash Deductible: Each Calendar Year, 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 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Calendar Year. 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 Calendar Year. 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 Calendar Year. Once the Per Covered Person Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family must pay during each Calendar Year. Once the Per Covered Family Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Calendar Year.

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

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

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

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

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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.

Biologically-based Mental Illness: We pay benefits for the treatment of a Biologically-based Mental Illness 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.

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:
   1) ordered by Your Practitioner;
   2) 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. 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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured . 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.

Note to carriers: Use the following text for plans not issued in conjunction with an MSA or HSA
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.

Note to carriers: Use the following text for plans issued in conjunction with an MSA or HSA
We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment.

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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.

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

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

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.**

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

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

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. Except as stated in the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy, We do not cover drugs to treat Non-Biologically-based Mental Illnesses and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy.

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 Calendar Year, 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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.

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Non-Biologically-based Mental Illness and Substance Abuse: We limit what We pay for the treatment of Non-Biologically-based Mental Illness and Substance Abuse as those terms are defined in this Policy.

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 25% 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 Calendar Year. 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.
EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a

condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: 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 Preventive Care. 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey of Health and Senior Services.

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 Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Policy.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year 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 Calendar Year. 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
c) Heart
f) Heart-Lung
g) Heart Valves
h) Pancreas
i) Allogeneic Bone Marrow
j) Autologous Bone Marrow and Associated 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.]

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.

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 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 are 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 acknowledgment 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),** or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by 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.

[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.]]

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.

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

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

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non-Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and

c) as stated in this Policy for food and food products for inherited metabolic diseases.

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, except as stated in this Policy

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 or 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:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) 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 (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) 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.

Vision therapy, vision or 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.

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 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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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 for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

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

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.

[NETWORK AND OUT- 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.
A 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- Network Provider may be different than Our Network Provider Allowance; also, an Out- 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.

[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.]

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her 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.]

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 the requirements of that law.

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.
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).

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 E 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. 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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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 [__].

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.

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.

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

COINSURANCE. The percentage of 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 Preventive Care;

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.

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

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

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) 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 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 Preventive Care provision of the COVERED CHARGES 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 /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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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

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

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

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

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose 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 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]

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 -NETWORK PROVIDER. A Provider which is not a 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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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-rays 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.

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 for its stated purpose by the state in which it operates.

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

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 for its stated purpose 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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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.

c) **[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 You are an Eligible Person, except as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person except: a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy except : a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..

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.

[SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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	25%
• Other Covered Charges -	10%

COINSURANCE CAP	After $1500/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 PER CALENDAR YEAR	
• for Preventive Care	NONE
• for immunizations and lead screening for children	NONE
• for all other Covered Charges	
per Covered Person	[$150, $500, $1000]
per Covered Family	[$300, $1000, $2000]
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/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$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 Calendar Year
• Occupational Therapy	30 visits per Covered Person per Calendar Year
• Speech Therapy	30 visits per Covered Person per Calendar Year
• Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
• if treatment, services or supplies are given by a Network Provider	[NONE]
• if treatment, services or supplies are given by an Out-Network Provider	10%, except as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person must incur each Calendar Year before no Coinsurance is required, except as stated below.

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

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given by a Network Provider	
• [Physician Visits	$10 per visit]
• [Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
• [Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
• for Preventive Care	NONE
• for immunizations and lead screening for children	NONE
• for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$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 Calendar Year
• Occupational Therapy	30 visits per Covered Person per Calendar Year
• Speech Therapy	30 visits per Covered Person per Calendar Year

• Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS	**SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
• if treatment, services or supplies are given by a Network Provider	[NONE]
• if treatment, services or supplies are given by an Out-Network Provider	10%, except as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person must incur each Calendar Year before no Coinsurance is required, except as stated below.

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

Coinsured Charge Limit:	$10,000 per Covered Person
CASH DEDUCTIBLE PER CALENDAR YEAR	
• for Preventive Care	NONE
• for immunizations and lead screening for children	NONE
• for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE	$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 Calendar Year
• Occupational Therapy	30 visits per Covered Person per Calendar Year
• Speech Therapy	30 visits per Covered Person per Calendar Year
• Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

[SCHEDULE OF BENEFITS	**SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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:	
• if treatment, services or supplies are given or referred by the PCP	[NONE]
• if treatment, services or supplies are given by non-referred Provider	10%, except as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by non-referred Provider	25%

COINSURED CHARGE LIMIT

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

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

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given or referred by the PCP	
• Physician Visits	[$10 per visit]
• [Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
• [Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by a non-referred Provider, or are not subject to a Copayment above	

• for Preventive Care	NONE
• for immunizations and lead screening for children	NONE
• for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
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/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$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 Calendar Year
• Occupational Therapy	30 visits per Covered Person per Calendar Year
• Speech Therapy	30 visits per Covered Person per Calendar Year
• Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.]

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 "Premiums 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 for 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:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

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

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

[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] preferred 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] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider, and he or she is free to change Providers at any time.

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

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Provider will bill him or her directly.

This Policy also has utilization review provisions. 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 may contact Our [Claim Office at the number shown on Your identification card.]

[POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ Provider Organization.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule of Benefits which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d) ***Out-Network Benefits*** mean the benefits shown in the Schedule of benefits which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ Provider Organization.]

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ Provider Organization]. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ PO.] The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Provider when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay Out-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-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ PO] by [phone or in writing].

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

[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.]

[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.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. 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-Network Benefits.

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 within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

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

Utilization Review

This Policy has utilization provisions. See the **Utilization Review** section of this Policy.

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

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals procedure when the plans are issued including Preferred Provider Organization or Point of Service provisions. If a carrier has had a Selective Contracting Arrangement approved by the New Jersey Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 Calendar Year. 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year.]

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

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

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

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

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

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

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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:
1) ordered by Your Practitioner;
2) 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. 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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured. 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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

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.**

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

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

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. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of this Policy.

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 Calendar Year, 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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 25% 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 Calendar Year. 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.

EXCEPTION: The Pre-Existing Conditions Limitation does not apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will credit the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Primary Care: 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 Preventive Care. 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and the New Jersey Department of Health and Senior Services.

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 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 Calendar Year 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 Calendar Year. 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) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated 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.]

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.

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 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 are 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	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty

Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	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 acknowledgment 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)**, or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by 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.

[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.]]

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.

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

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

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

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, except as stated in this Policy.

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 or 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:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) 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 (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) 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.

Vision therapy, vision or 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.

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 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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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 for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give you at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

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

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.

[NETWORK AND OUT 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.

A 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 Network Provider may be different than Our Network Provider Allowance; also, an Out 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.

[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.]

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her 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.]

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 the requirements of that law.

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).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

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 services provided. 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.

Premiums. We may only change the Premiums for this Contract if We change the Premiums 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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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 ____.

ALCOHOLISM. Abuse of or addiction to alcohol and does not include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

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 [ ]].

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

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

It must also:
carry out its stated purpose under all relevant state and local laws; or
be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
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 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.

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

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by 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, 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 any, 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:
furnished or ordered by a recognized health care Provider;
Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;
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
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.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal

organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:
is furnished mainly to help You meet Your routine daily needs; or
can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) 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 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 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 Contract'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 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 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 its support and maintenance. You have 31 days from 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 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:
radiology, ultrasound, and nuclear medicine;
laboratory and pathology; and
EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION/DETERMINATION/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:
designed and able to withstand repeated use;
used primarily for a medical purpose;
mainly and customarily used to serve a medical purpose;
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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). Refer to the Who is Eligible provision of the ELIGIBILITY section.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
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:
is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Contract.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
for whom, as of the date on which he or she seeks coverage under this Contract, the aggregate of the periods of Creditable Coverage is 18 or more months;

whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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.

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

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

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

[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, or 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:
approved for its stated purpose by Medicare;
accredited for its stated purpose by the Joint Commission; or
licensed, certified, or accredited for its stated purpose 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:
accredited as a hospital by the Joint Commission;
approved as a hospital by Medicare; or
licensed, certified, or accredited for its stated purpose 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, 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.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
in accordance with accepted medical standards in the community at the time;
not for Your convenience; and
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:
accredited for its stated purpose by the Joint Commission;
approved for its stated purpose by Medicare; or
licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, including Substance Abuse regardless of any underlying physical cause. As used in this Contract, a Mental or Nervous Condition does not include a Biologically-based Mental Disorder, or Alcoholism, as defined in this Contract.

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 mid-wife or nurse anesthetist, who:
is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
provides medical services which are within the scope of his or her 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.

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:
as a Member; and
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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)). That is:
the employer in the case of an employee benefit plan established or maintained by a single employer;
the employee organization in the case of a plan established or maintained by an employee organization; or
in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PRACTITIONER. A person who:
is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
provides medical services which are within the scope of his or her license or certificate and which are covered by this Contract.

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

PRE-ADMISSION TESTING. Consultations, X-rays 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:
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
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.

PROVIDER. A Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] [or Health Center] 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:
accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
approved for its stated purpose by Medicare; or
licensed, certified, or accredited for its stated purpose by the state in which it operates.

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

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. It carries out its stated purpose under all relevant state and local laws, and it is:
accredited for its stated purpose by the Joint Commission;
approved for its stated purpose by Medicare; or
licensed, certified, or accredited for its stated purpose 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:
intensive care units;
cardiac care units;
neonatal care units; and
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 but does not include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

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:
accredited for its stated purpose by the Joint Commission;
approved for its stated purpose by Medicare; or
licensed, certified, or accredited for its stated purpose by the state in which it operates.

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

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
have permanent operating and recovery rooms;
be staffed and equipped to give emergency care; and
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:

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

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to 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.

ELIGIBILITY

TYPES OF COVERAGE

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

SINGLE COVERAGE - coverage under this Contract for only one person.
FAMILY COVERAGE - coverage under this Contract for You and Your Dependent(s).
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.
HUSBAND AND WIFE COVERAGE - coverage under this Contract for You and Your Spouse.
[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

THE CONTRACTHOLDER -You, if You are an Eligible Person, [who lives, resides or works in the designated Service Area in the State of New Jersey] except as provided below.
SPOUSE - Your Spouse [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person except: a Spouse need not be a Resident; and except as provided below.
CHILD - Your Child [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract, except: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Member, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Member is a Resident.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

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.
ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN - You and/or 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
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.

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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]
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 month after the date Your application is received.
YOUR CHILD DEPENDENT'S NEWBORN - A Child born to Your Child Dependent is not covered under this Contract.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR, 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 / Calendar Year.
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/Calendar Year. Maximum of 30 days Inpatient care/Calendar Year. 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/Calendar Year. Maximum of 30 days inpatient care/Calendar Year. 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.
PREVENTIVE CARE	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if the Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CARE	Unlimited days, if preapproved.
THERAPEUTIC MANIPULATION	$15 Copayment/visit for a maximum of 30 visits per Calendar Year.
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 CARE 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.

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):
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.
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 for 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] [Contract's Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:
any Premium Due Date;
any date that the extent or nature of the risk under the Contract is changed:
by amendment of the Contract; or
by reason of any provision of law or any government program or regulation;
at the discovery of a clerical error or misstatement as described in the General Provisions section of this Contract.

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

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.

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]:

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

Diagnostic Services.
Casts and dressings.
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].
Infertility Services except where specifically excluded in this Contract.

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 Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury as stated in the Dental Care and Treatment provision of this Contract.
Prescription Drugs and contraceptives which require a Practitioner's prescription and the following non-prescription drugs and supplies: insulin needles and syringes and glucose test strips and lancets; colostomy bags, belts and irrigators
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.

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]

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 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:

Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a minimum of 72 hours following a modified radical mastectomy; and
a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if You, in consultation with the [Participating] Practitioner, determine that a shorter length of stay is medically appropriate.
As an exception to the Medically necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
a minimum of 48 hours of in-patient care in a Participating Hospital following a vaginal delivery; and
a minimum of 96 hours of in-patient care in a Participating Hospital following a cesarean section.

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

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.
General nursing care
Use of intensive or special care facilities
X-ray examinations including CAT scans but not dental x-rays
Use of operating room and related facilities
Magnetic resonance imaging
Drugs, medications, biologicals
Cardiography/Encephalography
Laboratory testing and services
Pre- and post-operative care
Special tests
Nuclear medicine
Therapy Services
Oxygen and oxygen therapy
Anesthesia and anesthesia services
Blood, blood products and blood processing
Intravenous injections and solutions
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
Private duty nursing only when Medically Necessary and Appropriate as certified by the [Network] [Participating] Specialist Practitioner or other attending Practitioner in concurrence with Your Primary Care Physician [or Care Manager] and approved in advance by Us.
The following transplants, when Medically Necessary and Appropriate: Cornea, Kidney, Lung, Liver, Heart, Heart-Lung, Heart Valves, Pancreas.
Allogeneic 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.]

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]. Please note that this section does not address coverage for a Biologically-based Mental Illness.

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 non-medial 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.

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.

BIOLOGICALLY-BASED MENTAL ILLNESS. We cover treatment of a Biologically-based Mental Illness in the same way as We would cover any other Illness, if treatment is rendered by a [Participating Provider] [Network Practitioner] upon prior written referral by Your [Primary Care Physician] [[or] Care Manager]. We do not pay for Custodial Care, education or training.

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 non-medical 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 Alcoholism, and referral services for Alcoholism. 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.

Court-ordered Alcoholism admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

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 Hospital services performed within or outside Our service area without a prior written referral only if:
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.
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
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 Medical Emergency services within 30 days. You shall be responsible for payment for 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.

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 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.

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 or terminally Injured 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 a more cost effective setting in which to provide appropriate care.

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 Calendar Year. Services and supplies beyond 30 visits are not covered.

DENTAL CARE AND TREATMENT - We cover the diagnosis and treatment of oral tumors and cysts; and the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
the Injury occurs while You are covered under any health benefit plan;
the Injury was not caused, directly or indirectly by biting or chewing; and
all treatment is finished within 6 months of the date of the Injury.

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

For a Member who is severely disabled or who is a Child under age 6, We cover:
general anesthesia and Hospitalization for dental services; and
a medical condition covered by this Contract which requires Hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

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 domiciliary care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract..

Dose Intensive Chemotherapy, except as otherwise stated in this Contract.

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 Contract.

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 Contract; 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 services provided under workers' compensation, employer's liability, occupational disease or similar law.

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

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

Methadone maintenance.

Non-prescription drugs or supplies, except:
insulin needles and syringes and glucose test strips and lancets
colostomy bags, belts and irrigators.

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

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.
EXCEPTION: The Pre-Existing Conditions Limitation does not apply to a Federally Defined Eligible Individual, as defined in this Contract, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will credit the time a Member was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Contract, measured from the last date the Creditable Coverage was in force on a premium paying basis.

[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:

For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90)day supply.
For all other Prescription Drugs:

a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or
sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;
a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointment, enemas, etc.); or
one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or
one (1) vial containing no more than fifteen (15) milliliters of any optic or ophthalmic product; or
two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or
three(3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or
dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

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:

an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
the removal of nail roots; and
treatment or removal or 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 and Medicare). This provision applies whether or not You assert Your rights to obtain this 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;
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 (c) 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 his or her 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 the 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.

APPEALS PROCEDURE

[Appeals Procedure: Variable by Carrier as approved by the State of New Jersey.]

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 third party settlement;
a satisfied judgment; or
other means.

The repayment agreement shall be binding upon the Covered Person whether:
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
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 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.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Member may be covered under this Contract and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. We do this so the Member does not receive more in benefits, services and supplies than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Contract and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Contract and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Contract is the secondary plan. The primary plan (Medicare) pays first, without regard to this Contract. The secondary plan (this Contract) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We cover less than We would otherwise cover, We apply only that reduced coverage against payment limits of this Contract.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When coverage that should have been provided by this Contract has been provided by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that coverage. And if We provide more than We should have, We have the right to recover the excess coverage.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Contract, You have two options under the terms of Your motor vehicle insurance Contract. The option You select will also determine coverage of any resident relative in the named insured's household 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 Contract (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 Contract 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 primacy 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.

MEMBER PROVISIONS

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

IDENTIFICATION CARD
The Identification Card issued by Us to Members pursuant to this 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 Appeal Procedures.

INABILITY TO PROVIDE SERVICE
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this 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 provision of services, taking into account the impact of the event.

INDEPENDENT CONTRACTOR RELATIONSHIP

No [Network] [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 [Network] [Participating] Provider or other provider, institution, Facility or agency.

Neither the Contractholder nor any Member is our agent, representative or employee, or an agent or representative of any [Network] [Participating] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.

[Network] [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.

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

REFERRAL FORMS

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeal Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeal Procedure. We reserve the right to expedite the Appeal Procedure. If the Appeal Procedure results in a decision upholding 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 Appeal 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 a Member such information HMO deems is necessary to administer this Contract subject to all applicable confidentiality 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.

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 authorize 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.]

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:
it is shown in an endorsement on it signed by an officer of [Carrier].
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 officer of [Carrier].
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.
if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by an officer of [Carrier].

ASSIGNMENT
No assignment or 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.

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 the requirements of that law.

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 his or her 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 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.

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.

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.

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 this 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.

STATEMENTS
No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by 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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Contract.. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

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

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 [when that period ends.][as of the end of the period for which premium has been paid.]

Termination by Request - If You want to replace this 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:

You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]
You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)
termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)
with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)
subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may have become eligible for coverage.
[You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]

THE CONTRACT
The entire Contract consists of:
the forms shown in the Table of Contents as of the Effective Date;
the Contractholder's application, a copy of which is attached to the Contract;
any riders, endorsements or amendments to the Contract; and
the individual applications, if any, of all Members.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).

[EXHIBIT G]

(RESERVED)

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Amended by R.2002 d.331, effective October 7, 2002.
See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Expired, effective July 4, 2005.
See: 37 N.J.R. 2994(a).

EXHIBIT H

(RESERVED)

Expired, effective July 4, 2005.
See: 37 N.J.R. 2994(a).

EXHIBIT P

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT Q

CERTIFICATION OF COMPLIANCE WITH NEW JERSEY INDIVIDUAL HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:20-3.2 submit this form before marketing or issuing any of the standard plans, and by March 1 of every year thereafter. Submit this form to the IHC Board at the following address: 20 West State Street, PO Box-325, Trenton, New Jersey 08625. Affiliated carriers must file separate forms. Carriers must complete the certification as set forth in this Exhibit; the words in the Certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: _____
NAIC#: _____
Respondent's Name: _____
Respondent's Title: _____
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 and Explanation of Brackets (Exhibit T) as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

____ Plan A Exhibit A
____ Plan A/50 Exhibit U
____ 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 and Explanation of Brackets (Exhibit T) in the Appendix to N.J.A.C. 11:20.

Is the optional pre-existing conditions statement being included? ____ Yes ____ No

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/50 and A - E (To be completed by non-HMO carriers)

(1) Identify the standard plans to be offered as traditional indemnity contracts, if any.

Plan A*: ____ Plan A/50: ____ Plan B: ____ Plan C ____ Plan D: ____ Plan E* _____

*As of September 1, 1997, Plan A is available only for renewals of inforce Plan A business. As of November 1, 1998, Plan E is available only for renewals of inforce Plan E business.

(2) List all plans to be offered in conjunction with a selective contracting arrangement **(defined at N.J.A.C. 11:4-37)

PPO Plans:
Plan B: ____ Plan C____ Plan D: ____ Plan E____
POS Plans:
Plan C____ Plan D: ____ Plan E____

** A carrier must first have received approval of its selective contracting arrangement from the Departments of Health and Senior Services and Banking and Insurance before it may issue the standard individual plans through such arrangement. Note: Health Service Corporations are not subject to the statute and regulations relating to selective contracting arrangements. Such carriers should note the plans they are offering as if they were subject to selective contracting arrangements.

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the network and out network coinsurance levels in the space provided next to the plan (Ex. Plan D: 100%/80%), the copay options, and whether the plan requires election of a primary care physician.

PPO Plans:
Plan B: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____
Plan C: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____
Plan D: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____
Plan E: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____
POS Plans:
Plan C: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____

Plan D: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____
Plan E: ____ Physician Copay: ____ Hospital Copay: ____ PCP Election: ____

Attach copies of the schedule page for each of the PPO and POS plan options indicated above.

(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?

Centers of Excellence Features	_____ Yes _____ No
Child(ren) Only Coverage	_____ Yes _____ No
Care Manager Provisions	_____ Yes _____ No
High Deductible Options	_____ Yes _____ No

If yes: check the Plans and individual deductibles:
_____ Plan C: _____ $1500 _____ $2250
_____ Plan D: _____ $1500 _____ $2250

(6) How are Autologous Bone Marrow Transplants offered?
_____ in the policy
_____ mandated offer rider

(7) For POS Plans, how often may a female covered person use the services of a network gynecologist for non-surgical care without referral?
____ once per year
____ unlimited

(b) HMO Plan

(1) Check the copayment options being offered.
_____ $10 (Optional)
_____ $15 (Mandatory)
_____ $20 (Optional)
_____ $30 (Optional)

(2) How is prescription drug coverage being provided?
_____ subject to $15 Copayment
_____ subject to 50% Co-Insurance

(3) How are Autologous Bone Marrow Transplants offered?
_____ in the contract
_____ mandated offer rider

(4) Do the plans include any of the following as set forth by the IHC Board?

Child(ren) Only Coverage	_____ Yes _____ No
Care Manager Provisions	_____ Yes _____ No

(c) Compliance with Forms Changes

If this Certification is being submitted within one year of the effective date of forms changes, please complete the following:
Has the issue system been updated to reflect the changes to the policy forms which were effective during the prior year such that new plans issued on or after the effective date of the changes reflect all of the policy forms changes which were effective during the prior year ?
_____ Yes _____No
How are inforce policies/contracts being updated to reflect the policy forms changes which were effective during the prior year?
_____ reissue policies/contracts .
_____ riders mailed to policyholders/contractholders *

* NOTE: The rider option may only be used if the IHC Board stated that the compliance and variability rider would be an appropriate mechanism to update inforce plans. If the rider is permitted to be used and this option is selected, the text of the rider must be identical to the text provided by the IHC Board.

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

_____
Printed Name

_____
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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Administrative Correction.
See: 38 N.J.R. 1005(a).

EXHIBIT R

(RESERVED)

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Mandated Offer Rider".

EXHIBIT S

[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).

EXHIBIT T

EXPLANATION OF BRACKETS FOR INDIVIDUAL HEALTH COVERAGE STANDARD PLANS AND APPLICATION
Text which is enclosed in brackets may *only* be modified as described in this Exhibit. Unless otherwise stated, carriers have the option to either include or not include the standard text.

Plans B - D and A/50

1) The name of the Carrier, specific dates, page numbers, deductible amounts or premium information may be inserted, as appropriate.
2) **Dividend** text on the face page and in the General Provisions should only be included by mutual carriers.
3) The definition of **Care Manager** should only be included by carriers that utilize such a provider.
4) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee only if the plan is issued through or in conjunction with a Selective Contracting Arrangement.
5) Omit the **definitions** of Network Provider, Out-Network Provider and Service Area for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
8) Omit the **PPO, POS and Appeals** sections for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.).
9) The **Coinsurance Cap** provision in the Benefit Deductibles, Copayments and Coinsurance section should be included in plans which are *not* issued through or in conjunction with a selective Contracting Arrangement. Omit the Coinsured Charge Limit provision.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Hospital Charges** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available *via rider* should include the text of the first item "j" in the Transplant section. Omit the second item "j" and item "k". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "j" in the Transplant section. Include the second item "j" and item "k".
12) Carriers that do not use centers of excellence should omit the **Centers of Excellence** section.
13) Carriers may elect to omit the **Provider Relationship** provision in the General provisions.
14) Omit the **Network and Out-Network Provider Relationship** provision in the General Provisions for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
15) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Policy-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.
16) Carriers that issue Point of Service plans may elect to allow a female Covered Person to use the services of a **network gynecologist** without PCP referral for stated services on an unlimited basis, or may limit the use of a network gynecologist without PCP referral to once per year. Include only the paragraph in the Point of Service provisions which reflects the elected option (not available with Plan A/50.)

Plans issued through or in conjunction with a **Selective Contracting Arrangement** (not available with Plan A/50.)

1) Include the following definitions:

•Network provider
•Out-Network Provider
•Service Area

2) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee.
3) Sample **Schedule** text is included for a PPO plan without copayments, a PPO plan with copayments, and a POS plan. For plans which use copayments, include only the categories of services to which a copay will apply. The dollar amounts of the copayments should be consistent with the copayment options available with the IHC HMO plan.
4) Include the Preferred Provider Organization section if the plan is a PPO. Include the name of the PPO wherever XYZ appears.
5) Include the Point of Service section if the plan is a POS. Include the name of the provider organization wherever XYZ appears.
6) Carriers issuing a PPO or a POS plan may include **Appeals Procedures**.
7) Include the **Coinsured Charge Limit** text in the Benefit Deductibles, Copayments and Coinsurance section. The Coinsurance Cap provision should be omitted.
8) Include the Network and Out-Network Provider relationship provision in the General Provisions.

[Plans issued with $1500 and $2250 High Deductible Options (that could be used in conjunction with an MSA)] **For plans issued as high-deductible health plans that could be used in conjunction with an MSA or an HSA**

1) Include only the **Schedule of Benefits** page which specifies the high deductible options **and which is labeled for use with a high-deductible health plan. Specify the specific dollar amounts for the deductible and maximum out of pocket amounts. Refer to N.J.A.C. 11:20-3.1 for permissible dollar amounts**. Omit all other schedules.
2) Include the **Benefit Deductibles, Copayments and Coinsurance** section which addresses the maximum out of pocket amount. Omit the corresponding section which addresses Coinsurance Cap/Coinsured Charge Limit.

HMO Plan

1) The name of the Carrier, specific dates, page numbers, copayment amounts or premium information may be inserted, as appropriate.
2) Wherever a series of terms are shown in brackets, select the term that is consistent with the carrier's terminology or practice.
3) Omit **Care Manager** definition if a care manager is not used.
4) Omit **Coinsurance** definition if prescription drugs are provided subject to a copayment.
5) Omit **Health Center** definition if not applicable.
6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) Carriers that require **that the person live, reside or work in the Service Area** as an eligibility criteria should include the bracketed text; and also include the bracketed termination text which addresses when a person no longer lives, resides or works in the Service Area.
8) Bracketed text is shown in the **Payment of Premiums-Grace Period** and **Termination of the Contract-Renewal Privilege** sections to accommodate termination as of the end of the grace period or as of the paid-to-date. Include appropriate bracketed text.
9) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Inpatient Hospital** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available via *rider* should include the text of the first item "23" in the Transplant section. Omit the second item "23" and item "24". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants *as part of the standard plan* should omit the text of the first item "23" in the Transplant section. Include the second item "23" and item "24".
12) The **Dispensing limits for prescription drugs** should be included in the Exclusions section by carriers that impose such limits.
13) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Contract-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.

Application

1) Omit those bracketed Instructions and bracketed text which do not apply.
2) Use the term Policy or Contract, as appropriate.
3) Use the term insured, subscriber or member, as appropriate.
4) If proof of full time student status or disability is not required to be attached to the application, the text which directs that proof be attached should be deleted.
5) In the Coverage section, carriers should include text which is consistent with the standard plan options that the carrier offers.
6) Omit the quarterly and/or semi-annual premium payment modes if those modes are not available.
7) The use of the Pre-Existing Conditions Statement is optional.
8) The statement regarding the selection of a PCP may be included, at the option of the carrier.
9) The statement regarding the option to elect coverage for ABMT should only be included by those carriers that make the benefit available via rider.
10) The variable text a carrier includes in the statement regarding termination in the event of falsified information should be consistent with the election of the carrier regarding termination as of the effective date, or immediately. Refer to item 15 of the explanation for Plans B - D and A/50, and item 13 of the explanation for the HMO plan.
11) Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.

New Rule, R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Administrative Correction.
See: 38 N.J.R. 1005(a).

EXHIBIT U

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan (A/50).

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 (PLAN A/50)
(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 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 BASIC Health Benefits Plan, Plan A/50.

[Dividends are apportioned each year.]

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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 [____].

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

ALCOHOLISM. Abuse of or addiction to alcohol. Alcoholism does not include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

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.

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

BIRTHING CENTER. 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.

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

COINSURANCE. The percentage of 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 Preventive Care;
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.

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

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

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:
is furnished mainly to help You meet Your routine daily needs; or
can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) 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 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 Preventive Care provision of the COVERED CHARGES 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/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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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

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

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

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

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 for its stated purpose 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 for its stated purpose 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 a [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.

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, 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 for its stated purpose by the state in which it operates.

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-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

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

NON-COVERED 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.

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

PARTIAL HOSPITALIZATION. Day treatment services for Non-Biologically-based Mental Illnesses 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.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, 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-rays 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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board.

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 for its stated purpose by the state in which it operates.

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

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

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

SKILLED NURSING 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 for its stated purpose 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 does not include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

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 for its stated purpose 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 for its stated purpose by the state in which it operates.

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

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 You are an Eligible Person, except as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except:** a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident.

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 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]

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.

SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR 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 per Calendar Year.

COINSURANCE:
(For All Covered Charges - 50%

COINSURANCE CAP After $5000/Covered Person, $10,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:
- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Non-Biologically-based Mental Illness and Substance Abuse
- Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR
- for Preventive Care NONE
- for immunizations and lead screening for children NONE
- for all other Covered Charges
  - per Covered Person [$1000, $2500, $5,000, $10,000]
  - per Covered Family [$2000, $5000, $10,000, $20,000]

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

HOME HEALTH CARE 365 days, if preapproved per Calendar Year.

SKILLED NURSING CARE 120 days of confinement/Covered Person, if preapproved per Calendar Year.

HOSPICE CARE Unlimited days, if preapproved.

NON-BIOLOGICALLY-BASED MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS Up to $5,000/Calendar Year combined Inpatient and Outpatient.
Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $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 per Calendar Year.

THERAPY SERVICES
- Physical Therapy 30 visits per Covered Person per Calendar Year
- Occupational Therapy 30 visits per Covered Person per Calendar Year
- Speech Therapy 30 visits per Covered Person per Calendar Year
- Cognitive Rehabilitation Therapy 30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

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.

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 "Premiums 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 for 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:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

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

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

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, 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 Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, 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 Calendar Year. 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 Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Non-Biologically-based Mental Illnesses 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 Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year.

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

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

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

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

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. 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.

Biologically-based Mental Illness: We pay benefits for the treatment of a Biologically-based Mental Illness 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.

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:
1) ordered by Your Practitioner;
2) 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. 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 or terminally Injured 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 or terminally Injured 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 or terminal Injury.

"Terminally Ill" or "Terminally Injured" 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 or terminally Injured. 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 the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

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.**

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

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

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. Except as stated in the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy, We do not cover drugs to treat Non-Biologically-based Mental Illnesses and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Non-Biologically-based Mental Illnesses and Substance Abuse section of this Policy.

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 Calendar Year, 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 "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

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.

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Non-Biologically-based Mental Illness and Substance Abuse: We limit what We pay for the treatment of Non-Biologically-based Mental Illness and Substance Abuse as those terms are defined in this Policy.

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 50% 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 Calendar Year. 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.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: 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 Preventive Care. 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 as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and the New Jersey Department of Health and Senior Services.

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 Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Policy.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year 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 Calendar Year. 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) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated 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.]

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.

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 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 are 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	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

MEDICAL PROCEDURES	DIAGNOSTIC PROCEDURES
Lower Back Medical Care	Cardiac Catheterization
	CAT SCAN
	Cystoscopy
	Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care	Hospice Care
Skilled Nursing Care	Infusion Therapy
Maternity Care (See STEP 2(a))	

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 acknowledgment 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)**, or as soon as reasonably possible, 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 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 CONFIRMS 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.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by 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.

[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.]]

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.

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

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

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

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

Pre - Existing Conditions, for the first 12 months of coverage in effect for You and Your Dependents, except as stated in this Policy.

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 or 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:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) 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 (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy; or

p) 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 Charges Covered with Special Limitations" under "Transplants."

Transportation; travel.

Vision therapy, vision or 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.

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 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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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.

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 such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES 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 resident relative in the named insured's household 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.

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 for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)

b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident; (We will give you at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market; or
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

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

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.

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.

[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.]

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her 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.]

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 the requirements of that law.

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

New Rule, R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).

EXHIBIT V

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 BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN
As required by P.L. 2001, c.368

[Policy] Term. The [Policy] takes effect on [_____], the [Policy] Effective Date. The term of this [Policy] starts on Your Effective Date, and may be renewed each year on the Anniversary Date, subject to the terms and conditions of this [Policy].

[Premium Due date: [ ]]

THIS POLICY IS A LIMITED BENEFITS PLAN AND DOES NOT PROVIDE COMPREHENSIVE MAJOR MEDICAL COVERAGE

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

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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].

ACCREDITED SCHOOL. A school approved by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or

Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

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

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.

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

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period.

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.] *[Note to carriers: Include if issued as a managed care plan that uses care managers.]*

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this [Policy] pays any benefits for such charges. The Deductible is shown in the Coverage Schedule. The Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the "Cash Deductible" provision of this [Policy] for details.

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

COINSURANCE. The percentage of a Covered Charge that must be paid by You, as shown in the Coverage Schedule. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Charges.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. [You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.]

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

[COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in 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 wellness care;
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.] *[Note to carriers: Include if issued as a non HMO-based plan. HMO based plans should use the Covered Services or Supplies text that follows.]*

COVERED PERSON. An Eligible Person who is insured under this [Policy]. Throughout this [Policy], Covered Person is often referred to using "You" and "Your."

[COVERED SERVICES OR SUPPLIES. The types of services and supplies described in 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 wellness care;
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.] *[Note to carriers: Include if issued as an HMO-based plan. Non-HMO based plans should use the Covered Services or Supplies text that appears above.]*

Read the entire Contract to find out what We limit or exclude. *[Note to carriers: Include if issued as an HMO-based plan.]*

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

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

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

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

DEPENDENT.
a) Your:
1) spouse;
2) unmarried Child who is Your own issue, Your legally adopted Child, or Your step-Child until the Child's 19th birthday. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat 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, and who is enrolled as a full-time student at an Accredited School (We may 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 Wellness benefit provision of this [Policy], Diagnostic Services are not covered under this [Policy] if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION/DETERMINE. Our sole right to make a decision or determination. 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.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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

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

We will also not cover any technology or any Hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of 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 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this [Policy], the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or Hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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.

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

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

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally Injured.

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 either:
a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, 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.

ILLNESS (OR ILL). A sickness or disease suffered by You or a description of You suffering from a sickness or disease.

INJURY (OR INJURED). All damage to a Covered Person's Body and all complications arising from that damage or a description of You suffering from such 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 settings.

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

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, or Injury;
c) in accordance with generally accepted medical practice;
d) not for Your convenience;
e) the most appropriate level of medical care that You need; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

MEDICAID. 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.

[[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.] You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.] *[Note to carriers: Include if issued as a plan with network or participating providers.]*

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

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

NON-COVERED CHARGES. 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 Charges. Utilization Review Penalties are also Non-Covered Charges.

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

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

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

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

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. §1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

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

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

[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.

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.

Complications of pregnancy are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. Complications of pregnancy are defined at N.J.A.C. 11:1-4.3.

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

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

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the lesser of:
a) The reasonable and customary charge for the service or supply as set forth in the Prevailing HealthCare Charges System (PHCS) data using the 80th percentile; or
b) The negotiated fee, if any, between [Carrier] and the Provider for the service or supply.] *[Note to carriers: Carriers that issue this plan as an HMO may omit this definition.]*

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

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

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

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

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

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

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

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

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

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

SURGERY.
a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) The correction of fractures and dislocations; or
c) Reasonable and Customary pre-operative and post-operative care.

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

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

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

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

WE, US, OUR. [Carrier].

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

ELIGIBILITY

TYPES OF COVERAGE

A [Policy]holder 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 whom 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.

WHO IS ELIGIBLE

a) **The [Policy]holder** - You, if You are an Eligible Person, except as provided below.
b) **Spouse** - Your Spouse, who is an Eligible Person **except**: a Spouse need not be a Resident; and except as provided below.
c) **Child** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this [Policy] **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **Eligibility If You Are Covered Under Another Individual [Policy]** - You and/or Your Dependents are eligible for coverage under this [Policy] if this [Policy] replaces another individual [Policy] under which You and/or Your Dependents are covered. You may request termination of the replaced individual [Policy] 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 Dependents may be eligible for coverage under this [Policy] only during the open enrollment period which occurs each year during the month of November, 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 of the month following 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 without additional premium 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 provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid. [[You should notify Us of the birth of the newborn Child as soon as possible.]

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 month after the date Your application is received.

COVERAGE SCHEDULE

Copayments:	
•Hospital Confinement	$500 per Covered Person per Period of Confinement
•Inpatient Care for Biologically Based Mental Illness	$500 per Covered person per Period of Confinement
•Outpatient and Ambulatory Surgery	$250 per Covered Person per Surgery
•Emergency Room Services	$100 per Covered Person per Visit
•Outpatient Physical Therapy	$20 per Covered Person per Visit
•All other Covered Services and Supplies	None

[**NOTE:** You may be required to pay an amount in excess of the above Copayments if the Provider's bill exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: This text should be included when there is a possibility of balance billing.]*

Deductible:	
•Wellness benefit	$50 per Covered Person per Calendar Year
•All other Covered Services and Supplies	None
[Policy]holder Coinsurance:	
•Alcohol and Substance Abuse Inpatient and Outpatient	30%
For Inpatient Care, Coinsurance applies *after* the payment of the Copayment	
•Biologically Based Mental Illness Outpatient Care	30%
•Wellness Benefit	20%
Coinsurance applies *after* the payment of the Deductible	
•All other Covered Services and Supplies	NONE
Coverage Limits:	
•Hospital Confinement	90 days per Covered Person per Calendar Year
•Biologically Based Mental Illness	
Inpatient Care	90 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per Calendar Year
•Alcohol and Substance Abuse	
Inpatient Care	30 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per Calendar Year
•Physical Therapy (Outpatient)	30 visits per Covered Person per Calendar Year
•All Other	Unlimited

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.

Maximum Benefits

•Out-of-hospital diagnostic tests	$500 per Covered Person per Calendar Year
•Wellness benefit	$600 per Covered Person per Calendar Year
•Practitioner visits for injury or sickness	$700 per Covered person per Calendar Year
•All other services and supplies:	Unlimited

PREMIUM RATES AND PROVISIONS

PREMIUM RATES
[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.	[$]
For Husband and Wife Coverage.	[$]

We have the right to prospectively change the Premium rate set forth in this [Policy] as described below.

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.

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.

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

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in this [Policy]. We have the right to prospectively change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that the extent or nature of the risk under the [Policy] is changed:
•by amendment of the [Policy]; or
•by reason of any provision of law or any government program or regulation;
c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this [Policy].

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

[CONTINUATION OF CARE

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

We shall assure continued coverage of covered services at the contract rate by a terminated Practitioner for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated Practitioner. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

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

For a Covered Person who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the Practitioner for the duration of the treatment or for up to 12 months, whichever occurs first.

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

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

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

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

If We refer a Covered Person to a Non-Network Provider, the service or supply shall be covered as a network service or supply. We are fully responsible for payment to the Practitioner and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.]

[Note: Include this text if the plan is issued as a managed care plan.]

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

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

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

[Note: Used only if coverage is offered as Indemnity POS.]

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered [Charges] [Services or Supplies] that exceed the Deductible applicable to wellness benefits before We [pay any benefits] [cover services or supplies] for those charges. The Deductible is shown in the Coverage Schedule of this [Policy]. The Deductible cannot be met with Non-Covered [Charges] [Services or Supplies]. Only Covered [Charges] [Services or Supplies] You [incur] [receive] for wellness services and supplies while insured can be used to meet the Deductible for those charges.

Once the Deductible is met, We [pay benefits] [provide coverage] for other wellness benefits above the Deductible amount incurred by You, subject to the Coinsurance requirement and maximum benefit. But all charges must be incurred while You are insured by this [Policy].

Copayment: You must pay the applicable Copayment for each of the services shown in the Coverage Schedule. After the payment of the Copayment, We will pay [the Reasonable and Customary Charges] *[Note to carriers: Carriers may omit the reference to reasonable and customary if issued as an HMO plan.]* for services and supplies, subject to the applicable Coinsurance, coverage limits and maximum benefits as shown in the Coverage Schedule. [You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: Include this text if there is a possibility of balance billing.]*

Coinsurance: Coinsurance is the percentage of a Covered Charge that a Covered Person must pay for services and supplies as shown in the Coverage Schedule.

COVERED [CHARGES] [SERVICES OR SUPPLIES]

We will [pay benefits] [provide coverage] for Medically Necessary and Appropriate treatment of an Injury or Illness and for Wellness benefits subject to the terms and conditions of this [Policy].

[Any of the following services which are coverage on an outpatient basis are covered only at the Primary Care Physician's office selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] or [Care Manager]. Services of a Specialist Practitioner which are covered under this [Policy] are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office 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]. The Inpatient 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 subject to Our preapproval.] *[Note to carriers: Include if issued as a managed care plan.]*

[OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS [POLICY].] *[Note to carriers: Include only if the Utilization Review text is included.]*

This section lists the types of [charges] [services or supplies] 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 and Substance Abuse: We [pay benefits] [provide coverage] for Inpatient and Outpatient treatment of Alcoholism and Substance Abuse. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement and the Alcohol and Substance Abuse Coinsurance as shown on the Coverage Schedule. [Benefits] for Outpatient care [are] [is] subject to the payment of the Alcohol and Substance Abuse Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note:* The Coverage Limits for Alcohol and Substance Abuse are separate from the Coverage Limits for Hospital Confinement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Immunizations and Lead Screening: We will cover charges for:

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

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

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

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

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

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

Pre-Admission Testing: We cover x-rays and laboratory tests in connection with pre-admission testing needed for a planned Hospital admission or Surgery. We cover these tests if:

a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

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

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

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

We cover Radiation Therapy and Physical Therapy when it is provided on an Inpatient basis and on an Outpatient basis. We only cover Hydrotherapy when it is provided on an Inpatient basis. Benefits for Outpatient Physical Therapy are subject to the payment of the Copayment shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.
Wellness Benefit: We cover wellness services and supplies. Wellness services and supplies include but are not limited to: routine physical examinations, diagnostic services, vaccinations, inoculations, x-ray, mammography, pap smear, bone density testing, nicotine dependence treatment, lead screening and screening tests related to wellness services. Benefits are subject to the payment of the Deductible and Coinsurance as shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

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

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

EXCEPTION: The Pre-Existing Conditions Limitation does not apply to a Federally Defined Eligible Individual, as defined in this [Policy], provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will credit the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this [Policy], measured from the last date the Creditable Coverage was in force on a premium paying basis.

[Note to carriers: The following Utilization Review text should not be included if issued by an HMO]

[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.

If You or Your Practitioner do not request Our authorization 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.

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, procedures, services or supplies were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the Grievance 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 seco.. 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].

SURGICAL PROCEDURES REQUIRING PREAPPROVAL

Adenoidectomy	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

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-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.

(b) For 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),** or as soon as reasonably possible, 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, services 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].

EXCLUSIONS

The following are not Covered [Charges] [Services or Supplies] 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

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

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

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

Birthing center charges

Blood or blood plasma which is replaced by You

Broken appointments

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

Chemotherapy

Christian Science

Completion of claim forms

Conditions related to behavior problems or learning disabilities

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

Custodial Care or domiciliary care

Dental care or treatment, including appliances and dental implants

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

Durable medical equipment

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

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

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

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

Food and food products

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

Herbal medicine

Home health care

Hospice care

Hypnotism

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

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

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

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

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

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

Non-Prescription Drugs or supplies

Nutritional counseling and related services

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

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

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

Prescription drugs obtained while not confined in a Hospital

Private duty nursing

Rehabilitation center charges

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 wellness 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

Second opinion charges

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) 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;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government Hospital unless the services are for treatment: (a) of a non-service Emergency; or (b) by a Veterans' Administration Hospital of a non-service related Illness or Injury; or (c) the Hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
j) provided by or in any locale outside the United States other than in the case of an 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;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this [Policy];
n) which are specifically limited or excluded elsewhere in this [Policy];
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the [Policy];
p) which You are not legally obligated to pay.

Skilled Nursing Facility charges

Skilled nursing care charges

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

Temporomandibular Joint Disorder (TMJ) Treatment

Therapeutic Manipulation

Therapy services, except as specifically covered under this [Policy]

Transplants, except to the extent a service or supply associated with a transplant is specifically covered under this [Policy].

Transportation; travel

Treatment of a Non-Biologically-based Mental Illness

Vision therapy, vision or 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

[Note to carriers: Include the Claims Procedures text in plans that require claims submissions.]

[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 and 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 [Policy]holder;
b) [Policy]holder'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 give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

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

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. or N.J.A.C. 8:38A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

GRIEVANCE PROCEDURE
[Carriers must include the disclosure requirements set forth in N.J.A.C. 8:38A-3.2]

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

MEMBER PROVISIONS

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

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

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

INABILITY TO PROVIDE SERVICE
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this [Policy], or similar causes, the rendition of medical or hospital benefits or other services

provided under this [Policy] is delayed or rendered impractical. We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

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

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

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

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

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

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

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

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

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

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

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 an 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 authorize Your treatment for a [Biologically Based, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this [Policy] and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a [Policy] or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable Expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this [Policy] or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an Allowable Expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an Allowable Expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this [Policy] if this [Policy] had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this [Policy] and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expenses under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this [Policy] and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This [Policy] is the secondary plan. The primary plan (Medicare) pays first, without regard to this [Policy]. The secondary plan (this [Policy]) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We will apply only that reduced amount against payment limits of this [Policy].

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this [Policy] has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.]

SERVICES 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 resident relative in the named insured's household 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 New Jersey 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 New Jersey 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.

GENERAL PROVISIONS

THE [POLICY]
The entire [Policy] consists of:
a) the [Policy]holder's application, a copy of which is attached to the [Policy]; and
b) any riders, endorsements or amendments to the [Policy].

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this [Policy], unless it is contained in a written statement 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 the consent of anyone else with a beneficial interest in it. The [Policy]holder 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' written notice to the [Policy]holder, and as provided in (b) and (c) amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under will be made without the approval of the Individual Health Coverage Program 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 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 [Policy]holder, 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 [Policy]holder, it is shown in an amendment to it signed by the [Policy]holder 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 for the new Plan, and any unearned premium will be refunded. If You want to end this [Policy] and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the [Policy] be terminated at the end of any period for which Premiums have been paid. Then the [Policy] will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the [Policy], or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the [Policy]; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the 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) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

Also, Dependent coverage ends when the [Policy]holder'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].

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.

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.

CONVERSION PRIVILEGE
If Your spouse loses coverage due to a divorce, he or she may apply for his or her 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.

CONFORMITY WITH LAW
Any provision of this [Policy] which is in conflict with the laws of the state in which the [Policy] is issued, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

GOVERNING LAW
This entire [Policy] is governed by the laws of the State of New Jersey.

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a). 35 N.J.R. 1290(a).