(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period unless the member has been granted a full exemption from assessments for the preceding two-year calculation period by the Board in accordance with N.J.A.C. 11:20–9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about May 1 of the year following every two-year calculation period, of the total reimbursable net paid losses for the preceding two-year calculation period and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period.

2. On or about September 1 of the year following every two-year calculation period, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding two-year calculation period.

3. The IHC Program Board may, as necessary, make reconciliations from the preliminary notice of the assessment for reimbursable net paid losses which may include adjustments in market share and adjustments for deferrals granted.

4. Upon the resolution of all outstanding matters including audits of reimbursable losses and appeals filed pursuant thereto, the IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the appropriate two-year calculation period by invoice stating the dollar amount then due or credit, if any, against future assessments. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

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

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

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

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

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

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

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20–11.

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

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

(g) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the two-year calculation period. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment

not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Upon receipt of notice that amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board and provide notice to the carrier of the principal amount and interest amount. The calculated amount shall be returned to the member with interest within 30 days from the date the interest has been calculated.

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.

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20–3.1 Benefits provided

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

1. Plan A, Exhibit A;

2. Plan B, "The Basic 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; and

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

(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 B, C, D and E as set forth in Exhibits B through E, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plans B, D, and E 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 Plan 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 either or both of the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. $1,500 per individual or in the case of a family unit, $3,000 per family unit;

ii. $2,250 per individual or in the case of a family unit $4,500 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 B through E 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.

(d) Each of the standard health benefits plans, except 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 shall 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 E 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 and $20.00 may be substituted for deductibles applicable to one or more of the in-network benefits;

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, Plan D shall have an out-network level of 80 percent, and Plan E shall have an out-network level of 90 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.

11:20–3.2 Policy forms

(a) For standard health benefits plans policies effective on or after January 1, 1995, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F, 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, D and E as described in the Explanation of Brackets, Exhibit T, in conjunction with the standard policy forms set forth as Exhibits B through E.

(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.

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 variable text set forth in Exhibits A, B, C, D, E and F 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".

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20–4.1 Standard application form

All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G with the variable text explained on the Explanation of Brackets, Exhibit T of the Appendix to this chapter.

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 Correction.
See: 27 N.J.R. 1424(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.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20–5.1 Standard claim form

All members offering health benefits plans or other health insurance policies to individuals, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing system), shall require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions set forth in Exhibit H shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB–92 set forth as Exhibit I shall be the standard claim form for all hospital inpatient services.

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.

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 2b(1) and 3 of the Act (N.J.S.A. 17B:–27A–3b(1) and 17B:27A–4).

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 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 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;

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date, and may be developed on different rate tiers for: individuals; husband/wife; adult/child(ren); family; and, at the option of the carrier, child(ren) only coverage, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals;

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

i. The rates being submitted;

ii. All information used in the development of the rates;

iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

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

i. A statement that the informational filing is complete; and

(c) With respect to coverage under an HMO contract, the following apply, notwithstanding (a) and (b) above:

1. A person who participates, or is eligible to participate, only in a group health benefits plan under an HMO contract may choose, only during the open enrollment period, to be covered under any standard health benefits plan, other than the standard HMO benefit plan.

(d) A carrier making determinations under (b) above with respect to a person who participates, or is eligible to participate, in more than one group health benefits plan, shall decide which group health benefits plan to compare with a standard health benefits plan, as follows:

1. If a person is seeking to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement than the group health benefits plan, the carrier shall compare the group health benefits plan with the higher, or highest, deductible and policyholder coinsurance requirement.

2. If a person is seeking to be covered by a standard health benefits plan with a lower deductible and policyholder coinsurance requirement than the group health benefits plan, the carrier shall compare the group health benefits plan with the lower, or lowest, deductible and policyholder coinsurance requirement.

(e) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above shall not consider any separately applicable deductible and policyholder coinsurance requirements for specified covered services.

(f) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above, with respect to a health benefits plan delivered under a selective contracting arrangement, shall use the in-network benefit as a basis for comparison.

(g) A carrier determining whether a group health benefits plan covers general services, according to (a) and (b) above, shall not consider any limits, coinsurance, copayment or deductible requirements which may apply to a specific type of general service, (or a covered service within a type of general service) separately from the other general services (or covered services) under either the group health benefits plan or the standard health benefits plan.

(h) Notwithstanding (a), (b) and (c) above, a carrier shall not offer a person coverage by a standard health benefits plan unless:

1. The person is required to pay a portion of the premium for coverage by the group health benefits plan in which the person participates, or is eligible to participate; and

2. The person's coverage by a group health benefits plan has been terminated or will terminate no later than the day before the effective date of the standard health benefits plan, except as extension of benefits provisions under the group health benefits plan or by law may be applicable.

(i) A person who is eligible only for continuation of coverage under an employer's group health benefits plan required by State or Federal law, including, but not limited to, N.J.S.A. 17B:27A–27 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and amendments thereto, may choose to be covered by any standard health benefits plan in lieu of continuing to participate in the group health benefits plan.

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).
In (c)1, deleted "plan E with a $150.00 cash deductible or" following "health benefits plan, except".
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (c), substituted "other than" for "except" in 1, and deleted 2; in (h), substituted "the day before" for "30 days after" in 2; and in (i), added an N.J.S.A. reference.

11:20–12.5 Selection of a standard health benefits plan by a person covered by an individual health benefits plan

(a) A person who is covered by an individual health benefits plan other than one of the standard health benefits plans issued pursuant to this chapter may choose at any time, to replace that health benefits plan with any standard health benefits plan. A carrier shall not offer a person coverage by a standard health benefits plan unless the person's coverage by the individual health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan. As long as the covered person notifies the carrier that issued the prior individual health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate a prior individual health benefits plan as required above, the standard health benefits plan that was intended to replace it shall be of no force and effect.

(b) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 31 days may choose, at any time, to be covered by a standard health benefits plan with the same or higher deductible and the same or higher policyholder coinsurance requirement than the standard health benefits plan being replaced, except that a person who is covered by standard health benefits plan A may choose, only during the open enrollment period, to be covered by any other standard health benefits plan. A carrier shall not offer a person coverage by a standard

health benefits plan unless the coverage by the standard health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan. As long as the covered person notifies the carrier that issued the prior standard health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate the prior standard health benefits plan as required above, the prior standard health benefits plan shall nevertheless be of no force and effect as of the effective date of the standard health benefits plan. The person shall return any benefit payments to the prior carrier and the prior carrier shall refund premiums paid for the period beginning with the effective date of the new standard health benefits plan.

(c) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 31 days may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a lower deductible or lower policyholder coinsurance requirement than the standard health benefits plans being replaced.

(d) The following rules apply to the HMO standard health benefits plan, notwithstanding (a), (b) and (c) above:

1. A person covered by standard health benefits plan E with a $150.00 deductible may replace that coverage, at any time, with coverage under an HMO standard health benefits plan.

2. A person covered by the HMO standard health benefits plan may replace that coverage, at any time, with coverage by an HMO standard health benefits plan with the same or higher copayment options than the HMO standard health benefits plan being replaced.

3. A person covered by standard health benefits plans A, B, C, or D or plan E with an individual deductible of $250.00, $500.00, $1,000, $1,500, $2,250 or $2,500 or in the case of the optional high deductible insurance plans, family unit deductible of $3,000 or $4,500 may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan.

4. A person covered by an HMO standard health benefits plan may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan with a lower copayment option than the HMO standard health benefits plan being replaced.

(e) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above shall not consider any separately applicable deductible or policyholder coinsurance requirements for specific covered services.

(f) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above, with respect to individual health benefits plans delivered under selective contracting arrangements, shall use the in-network benefit as a basis for comparison.

(g) Notwithstanding (b), (c) and (d) above, a carrier shall not offer a person coverage by a standard health benefits plan unless the person's coverage by the standard health benefits plan being replace has been terminated or will terminate no later than the effective date of replacement standard health benefits plan.

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 Correction.
See: 27 N.J.R. 1424(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).
In (a), in the second sentence, deleted "30 days after" following "will terminate no later than", inserted the third sentence, and in the last sentence, inserted "that was intended to replace it"; in (b), inserted second through sixth sentences; in (d)3, added deductible amounts of $1,500, $2,250 and $2,500; and in (g), deleted "30 days after" following "will terminate no later than".
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) and (c), substituted "31" for "30" preceding "days may choose"; and in (d), rewrote 3.

11:20–12.6 Penalties

The Board shall promptly provide the Commissioner with any information in its possession regarding possible violations of this subchapter by covered persons, employers, carriers, and insurance producers, and request that the Commissioner pursue all fines and penalties provided by law.

SUBCHAPTER 13. CERTIFICATION OF NON–MEMBER STATUS

11:20–13.1 Purpose and scope

The purpose of this subchapter is to provide a means by which carriers and other entities may be certified as non-members of the IHC Program.

11:20–13.2 Non-member status

(a) An entity is a non-member of the IHC Program if:

1. It is not a carrier as that term is defined in N.J.A.C. 11:20–1.2;

2. It is a carrier that neither has issued nor has inforce health benefits plans during the two-year calculation period of certification; or

3. It is a carrier that is permitted by law to be certified as a non-member.

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 "two-year calculation period" for "calendar year" in 2.

11:20–13.3 Filing of non-member certification requests

(a) A carrier or other entity that desires to be considered a non-member of the IHC Program for a preceding two-year calculation period shall file with the Board a request for non-member certification by March 1 following the end of the two-year calculation period for which non-member status is sought. Such request shall be sent to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

(b) A carrier or other entity that submits a request for non-member certification shall include an affirmative statement, certified by a duly authorized officer, of the reasons for which non-member status is requested.

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).
Rewrote (a) and deleted (c).

11:20–13.4 Decisions on filings by the Board

Within 45 days of receipt of a written request for non-member status, the Board shall grant or deny the request for non-member status in writing, specifying the reasons for the decision. If the Board does not grant or deny the written request for non-member status within 45 days of its receipt by the Board, the written request shall be deemed to be approved, except that the Board may extend the decision period for an additional 30 days by notifying a carrier or other entity, in writing, of the Board's need for additional information in order to make a determination.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Substituted "45 days" for "30 days" throughout.

11:20–13.5 Review and hearing by the Board

(a) A carrier or other entity that has been denied non-member status may appeal the Board's determination and request a hearing by the Board pursuant to the procedures set forth at N.J.A.C. 11:20–20.2.

(b) A carrier or other entity that requests a hearing shall be considered a member of the IHC Program until and unless the Board determines that the carrier is not a member.

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

SUBCHAPTERS 14 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20–17.1 Purpose and scope

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

(b) This subchapter applies to all members of the IHC Program that issue standard health benefits plans to individuals.

11:20–17.2 Definitions

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

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

"Conversion" means the first-time transfer of insurance coverage from a pre-reform plan, issued prior to August 1, 1993, to a standard plan.

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

"Insured" or "insured individual" means the number of individuals covered under an individual health benefits plan.

"Replacement contract" means the transfer of insurance coverage from one plan type to another with a different coinsurance, deductible or delivery system. A change in rating tier does not constitute a replacement contract.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), added new "Conversion", "Insured" or "insured individual" and "Replacement contract" definitions.

11:20–17.3 Filing requirements

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

(b) Members shall file hard copy enrollment status reports on a quarterly basis reflecting the information set forth in N.J.A.C. 11:20–17.4 and in the format of Part 1 of

Exhibit L which shall reflect data as of March 31, June 30, September 30 and December 31 of each year.

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

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

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

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "or renewing" following "issuing"; rewrote (b) and (c); and deleted (f).

11:20–17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity for Plan A, indemnity or PPO for Plan B, or indemnity, PPO and POS delivery systems for Plans C through E, the HMO plans, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. In section A of Part 1 of Exhibit L, Report By Contracts shall be calculated by adding the number of contracts inforce at the beginning of the period to the number of contracts representing new sales and conversions during the period, and subtracting the number of contracts lapsed during the period.

i. New sales and conversion contracts shall be reported separately by employment status and replacement status.

(1) Employment status shall be separated into three categories: employed, unemployed, unknown. Employment status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you employed?" If the response is yes, then the contract should be reported as employed. If the response is no, then the contract should be reported as unemployed. If the question has not been answered, the contract should be reported as unknown.

(2) Replacement status shall be separated into three categories: previously insured, previously uninsured, and unknown. Replacement status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you replacing existing coverage?" If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously insured. If the question has not been answered, the contract shall be reported as unknown.

ii. A reinstatement shall be reported by reducing the number of contracts lapsed;

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

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

3. In section C of Part 1 of Exhibit L, Report of Contracts By Rating Category shall be reported separately by rating category, that is: single; husband and wife (or two person); adult and child(ren); family; and child(ren) only, if applicable; and

4. In section D of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A-E or the required and permitted copayment options for the HMO Plan.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by indemnity for Plan A, indemnity or PPO for Plan B, or indemnity PPO and POS delivery systems for Plans C-E, the HMO plans:

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by the first three digits of the zip code, as of December 31 of the previous year;

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year beginning with December 31, 1994; and

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year beginning with December 31, 1994.

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

11:20–17.5 Penalties

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

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

11:20–18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the standard individual health benefits plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing: all standard individual health benefits plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to N.J.A.C. 11:20–3.1. This subchapter also establishes requirements for carriers in the event that the Board promulgates regulations repealing a specific plan, plan option, or deductible/copayment option.

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

11:20–18.2 Definitions

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

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

"Standard individual health benefits plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A–4b.

"State" means the State of New Jersey.

"Market withdraw" or "market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all standard individual health benefits plans and nonrenwal of all in force standard individual health benefits plans upon their respective anniversary dates without the carrier's offering replacement with a standard individual health benefits plan, except where such action is taken pursuant to N.J.S.A. 17B:27A–6.

"Plan option withdraw" or "plan option withdrawal" means a carrier's cessation of the issuance of a standard individual health benefits plan option, and the nonrenewal of all in force standard individual health benefits plans issued with that option upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A–6 or N.J.A.C. 11:20–18.5.

"Plan withdraw" or "plan withdrawal" means a carrier's cessation of the issuance of one of the standard individual health benefits plans, and the nonrenewal of all in force standard individual health benefits plans of that type upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A–6 or N.J.A.C. 11:20–18.5.

11:20–18.3 Carrier cancellation of standard individual health benefits plans

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

11:20–18.4 Cessation of offer and issuance of standard individual health benefits plans

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

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

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

i. The carrier intends to cease, or prior to July 6, 1998 has ceased, offering and issuing standard individual health benefits plans in New Jersey;

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

iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1–800–838–0935 for a free Individual Health Coverage Program Buyer's Guide.

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

(c) A carrier that has ceased offering and issuing standard individual health benefits plans, but has not withdrawn from the market in accordance with N.J.A.C. 11:20–18.5, may resume offering and issuing standard individual health benefits plan to an eligible person after it has notified the Board, in writing, that it intends to resume offering standard individual health benefits plans. Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

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

11:20–18.5 General provisions for market withdrawal

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

(b) A carrier that seeks to withdraw shall file with the IHC Board an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the standard individual health benefits plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A–2 et seq. and all rules promulgated thereunder, including the minimum loss ratio and policyholder refund requirements, and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the IHC Board at the address set forth in N.J.A.C. 11:20–2.1, and shall include an original and two copies of the following information:

1. The name of the carrier seeking to withdraw;

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

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

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

5. A statement indicating whether the carrier has filed for an exemption pursuant to N.J.A.C. 11:20–9 in the calendar year for which the application for market withdrawal application was filed;

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

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

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.]

TABLE OF CONTENTS

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.

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. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; 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.

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]
per Covered Family	[$500, $1000, $2000]

HOSPITAL INPATIENT COPAYMENT	
•per Covered person per day	$200
•maximum copayment per Covered Person per Period of Confinement	$1000
•maximum Copayment per Covered Person per 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.]

[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]
per Covered Family	[$1000, $2000]
HOSPITAL INPATIENT COPAYMENT	
• per Covered person per day	$200
• maximum copayment per Covered Person per Period of Confinement	$1000
• maximum Copayment per Covered Person per 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

- 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.

- 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.

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.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

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

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per 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, 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
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
Hospice 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
<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any Premium is not paid by the end of its grace period, the Policy will end 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 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.]

TABLE OF CONTENTS

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:

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (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 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.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)
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 Members or persons who may have become eligible for coverage.
h) [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:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Contractholder's application, a copy of which is attached to the Contract;
c) any riders, endorsements or amendments to the Contract; and
d) the individual applications, if any, of all Members.

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 G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
   (b) Medicare.
   (See item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:
1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1--Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2--Complete all information.

Section 3--Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4--This information is required. Please complete all information.

[Section 5--For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]--Applicant **must sign** this section and date this form or it will not be processed.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].

2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent

upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].

4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]

6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]

7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]

8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This section must be completed in its entirety.			BIRTHDATE			SEX	
LAST NAME	FIRST NAME	MI	MO	DAY	YR	M or F	Social Security Number
Applicant 1. [ ] Add [ ] Remove							__/__/__-__/__-__/__/__
Spouse 2. [ ] Add [ ] Remove							__/__/__-__/__-__/__/__
Child 3. [ ] Add [ ] Remove							__/__/__-__/__-__/__/__
Child 4. [ ] Add [ ] Remove							__/__/__-__/__-__/__/__
Child 5. [ ] Add [ ] Remove							__/__/__-__/__-__/__/__

*Attach sheet to list additional children. [Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.]

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? [ ] Yes [ ] No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: 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.

Street _____ Apt._____ City _____ State _____ Zip _____

[Do you live, reside or work in the [Carrier's] service area? [ ] Yes [ ] No]

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: [ ] Home [ ] Work

Are you a resident of the State of New Jersey? [ ] Yes [ ] No

Do you maintain a residence in any other state? [ ] Yes [ ] No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): _____

Name of Carrier _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____]]

COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

[PLAN B [[ ] Indemnity] [[ ] Preferred Provider] Deductible $500_____$1000_____

PLAN C [[ ] Indemnity] [[ ] Point of Service] [[ ] Preferred Provider] Deductible $1000 _____ $2500____
[per individual $1500_____$2250___
per family $3000_____ $4500___]

PLAN D [[ ] Indemnity] [[ ] Point of Service] [[ ] Preferred Provider] Deductible $500_____ $1000 _____
[per individual $1500_____ $2250___
per family $3000_____ $4500___]

PLAN E [[ ] Indemnity] [[ ] Point of Service] [[ ] Preferred Provider] Deductible $500 _____ $1000 _____

[HMO Plan [$10] $15 [$20] copayment.] [Well Child Care Option [ ] Yes [ ] No]]

Type of Contract: [ ] Single
[ ] Family
[ ] Adult & Child(ren)
[ ] Husband/Wife
[[ ] Child(ren)]

[If you selected Plan C or Plan D with a [$1500 per individual][[$2250 per individual] [$3000 per family] [$4500 per family] Deductible option, do you intend to participate in a Medical Savings Account?
[ ] Yes [ ] No]

Requested Effective Date - [Must be the 1st or 15th of the month]:_____

Type of Activity:

[ ] New [Subscriber]

[ ] Converting from existing (carrier) plan
ID #_____

[ ] Add/Remove Dependent
Reason _____
Date of Event _____

[ ] Name Change from _____ to _____

[[ ] Change of Primary Care Physician or Gynecologist]

[[ ] Change of Health [Care] Center from _____ to _____]

[[ ] Change of Primary Care Physician at Health [Care] Center]

[ ] Withdrawal From Coverage
Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

[ ] Monthly [[ ] Quarterly] [[ ] Semi-Annually]

[PAYMENT MODE:
[ ] Check
[ ] Money Order
[[ ] Credit Card Type_____ No. _____ Exp. Date_____]
[[ ] Automatic Bank Draft (attach voided check)_]

[[ ] Other _____ Amount $ _____]]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed? [ ] Yes [ ] No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? [ ] Yes [ ] No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other dependents eligible for coverage? If yes, specify.
Do you or other dependents currently have any other health care coverage? [ ] Yes [ ] No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? [ ] Yes [ ] No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced._____ _____ Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? [ ] Yes [ ] No If "Yes", attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?]
[Where? [carrier] of:]

[PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
a.	Alcoholism, Drug Abuse	____	____
b.	Arthritis	____	____
c.	Blood Disorder	____	____
d.	Back or Neck Disorder, Injury or Pain	____	____
e.	Cancer or Tumors	____	____
f.	Diabetes	____	____
g.	Gastro or Intestinal Disorder	____	____
h.	Heart Disorder or Condition or Chest Pain	____	____
I.	High Blood Pressure	____	____
j.	Kidney or Liver Disorder	____	____
k.	Lung or Respiratory Disorder	____	____
l.	Mental or Nervous Disorder	____	____
m.	Paralysis, Stroke or Epilepsy	____	____

n. Does Pregnancy Exist ____ ____
Expected Due Date: _____

2. During the past 6 months, have you or any dependent to be covered:

		Yes	No
a.	been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	____	____
b.	been advised to have treatment or surgery or testing that has not been done?	____	____
c.	been admitted to a hospital or other health care facility as an inpatient?	____	____
d.	taken prescribed medications?	____	____

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question	Name	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners
					]

[5. PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	[HEALTH CENTER* (if applicable)]	[GYNECOLOGIST OFFICE NO.]	[ESTABLISHED PATIENT]	PRIMARY CARE PHYSICIAN CHANGE	[HEALTH CENTER CHANGE]
1. Applicant				[ ] Yes [ ] No	[ ]	[ ]
2. Spouse				[ ] Yes [ ] No	[ ]	[ ]
3. Child				[ ] Yes [ ] No	[ ]	[ ]
4. Child				[ ] Yes [ ] No	[ ]	[ ]
5. Child				[ ] Yes [ ] No	[ ]	[ ]]
[Statewide Physician Network [ ] Health Center [ ]]						

[*When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.]
[NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to [carrier] for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995, c.100. [ ] Accept [ ] Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [carrier] may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to [carrier or its assignee] information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to [carrier or its assignee.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside live or work within the [carrier] service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that [carrier] will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application [carrier] can cancel this contract [as of the original effective date][immediately].

Applicant's Signature: _____ Date Signed _____

Spouse's Signature_____ Date Signed _____

Preparer's Signature: _____ DOBI License # _____ Date Signed _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

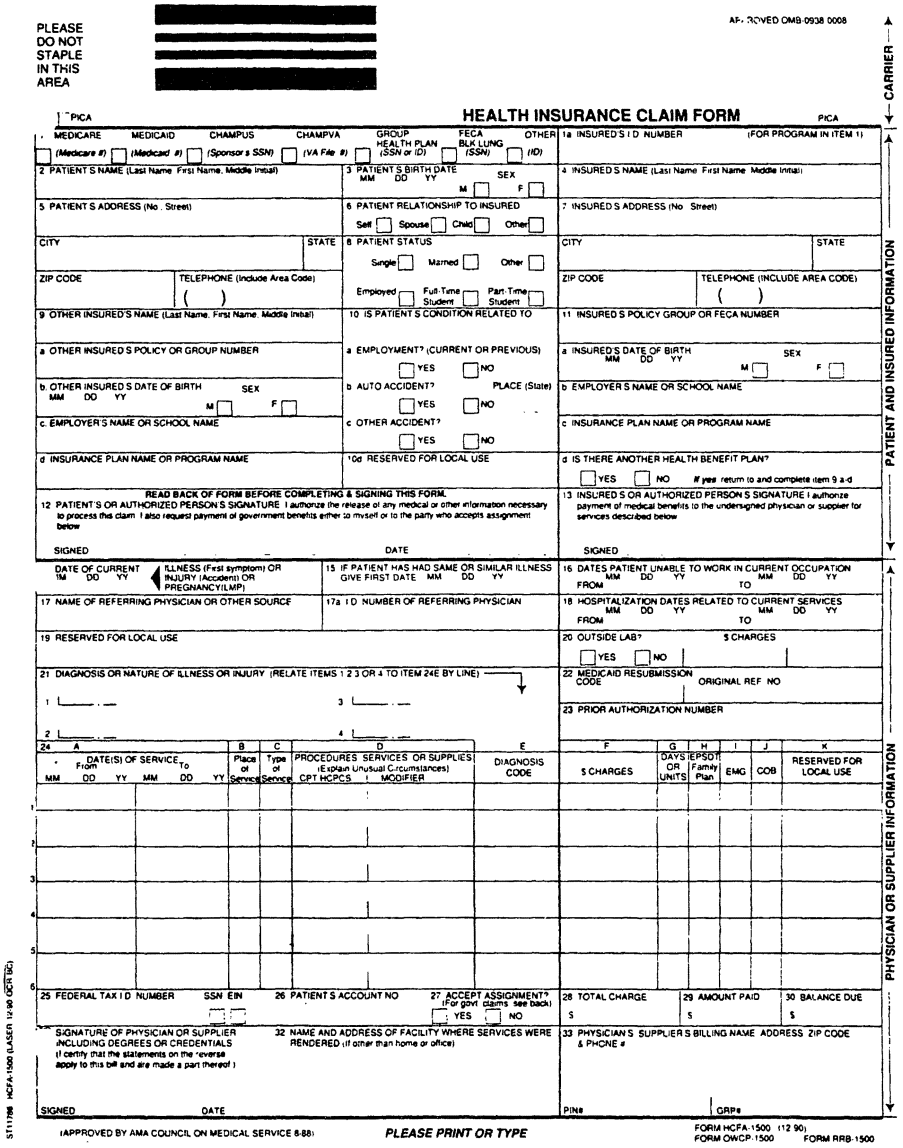
For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

[[6][7] AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]]

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).

EXHIBIT H



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938 0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY / FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY / FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1 2 3 4		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER / SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED _____ DATE _____		PIN# _____ GRP# _____

ST11786 HCFA-1500 (LASER 12/90) (OCR 12/90)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Carrier:
Completed By:
Title:
Phone:
Fax:
Quarter Ending:

New Jersey Individual Health Coverage Program
Enrollment Status Report
Part 1 of Exhibit L

		Plans Issued Prior to 8/1/93	Plan A	Plan B		Plan C		Plan D		Plan E		HMO Plan	Total Standard Plans End of Quarter
A	Report by Contracts		Indemnity	Indemnity	PPO	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
1	# of Contracts Inforce Beginning of Quarter												
2	# of New Sale, Conversion, and Replacement Contracts Issued During Quarter (See NOTE)												
a	# of Contracts Issued to Employed Individuals												
b	# of Contracts Issued to Unemployed Individuals												
c	# of Contracts Issued with Unknown Employment Status												
d	# of Contracts Issued to Previously Insured Individuals												
e	# of Contracts Issued to Previously Uninsured Individuals												
f	# of Contracts Issued with Unknown Previous Insurance Status												
3	# of Contract Lapses in Quarter												
4	# of Contracts Inforce End of Quarter [A4 = ((A1+A2)-A3)] [Note: A4=C6=D6]												
	NOTE: 2=(a+b+c)=(d+e+f)												

B	Report by Persons Insured												
1	# Insured Beginning of Quarter												
2	# of New Insureds During Quarter												
3	# of Insureds Lapsed During Quarter												
4	# Insured End of Quarter [B4 = ((B1+B2)-B3)]												

C	Report of Contracts by Rating Category												
1	# of Single Contracts by Rating Category												
2	# of Husband and Wife Contracts by Rating Category												
3	# of Adult and Child(ren) Contracts by Rating Category												
4	# of Family Contracts by Rating Category												
5	# of Child(ren) only Contracts by Rating Category												
6	# of Contracts Inforce End of Quarter [C6 = total of C1 through C5] [Note: A4=C6=D6]												

D	Report of Contracts by Deductible/Copayment Option												
1	# of Contracts with $150 or $250 Deductible or $10 Copay												
2	# of Contracts with $500 Deductible or $15 Copay												
3	# of Contracts with $1000 Deductible or $20 Copay												
4	# of Contracts with $2500 Deductible												
5	# of Contracts with $1500, $2250, $3000, or $4500 Deductible												
6	# of Contracts Inforce End of Quarter [D6 = total of D1 through D5] [Note: A4=C6=D6]												

E	Percentage of Contracts Issued to Persons Previously Uninsured	

11.20-17.5 Penalties: Failure to provide the enrollment status reports within the time and in the format required by this subchapter shall result in the imposition of penalties as may be provided by law.

Carrier:
Completed By:
Phone:
Fax:
Year Ending:

New Jersey Individual Health Coverage Program
Enrollment Status Report
Part 2 of Exhibit L

		Standard Plans										Total End of Quarter
		Plan A	Plan B		Plan C		Plan D		Plan E			
		Indemnity	Indemnity	PPO	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	HMO Plans	
A	Report of Contracts By Zip Code											
1	Zip Code: 070-073											
2	Zip Code: 074-075											
3	Zip Code: 076											
4	Zip Code: 077											
5	Zip Code: 078											
6	Zip Code: 079											
7	Zip Code: 080-084											
8	Zip Code: 085											
9	Zip Code: 086											
10	Zip Code: 087											
11	Zip Code: 088-089											
12	Total # of Contracts [A12 = total of A1 through A11]											
B	Report of Insured Males by Age Group											
1	Age 0-20											
2	Age 21-30											
3	Age 31-40											
4	Age 41-50											
5	Age 51-60											
6	Age 61-65											
7	Age 66-70											
8	Age 71 & Over											
9	Total Insured Males [B9 = total of B1 through B8]											
C	Report of Insured Females by Age Group											
1	Age 0-20											
2	Age 21-30											
3	Age 31-40											
4	Age 41-50											
5	Age 51-60											
6	Age 61-65											
7	Age 66-70											
8	Age 71 & Over											
9	Total Insured Females [C9 = total of C1 through C8]											

11.20-17.5 Penalties: Failure to provide the enrollment status reports within the time and in the format required by this subchapter shall result in the imposition of penalties as may be provided by law.

New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

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

EXHIBIT M

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO Standard Plan Provisions".

EXHIBIT 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 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 - 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 B: _____ Plan C _____ Plan D: _____ Plan E _____
*As of September 1, 1997, Plan A is available only for renewals of inforce Plan A 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)
(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).

EXHIBIT R

[Carrier]
MANDATED OFFER RIDER
[Policyholder]
[Policy No.]
Effective Date:

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in Plans B-E:

Item j. of the Transplant Benefits section of the COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is replaced with the following:

j. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

k. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in the HMO Plan:

Item 23. of the INPATIENT, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS provision of the COVERED SERVICES AND SUPPLIES section of the Contract is replaced with the following:

23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plan A should use the following text:

THE COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is expanded to include the following:

Transplants: We cover Medically Necessary and Appropriate Services and Supplies for:

a. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

b. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

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

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].

[Carrier should insert standard amendment closure and signature blocks.]

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT S

[Carrier]
AMENDMENT
[Policyholder]
Effective Date:
[
]
This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].
[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

EXHIBIT T

EXPLANATION OF BRACKETS FOR INDIVIDUAL HEALTH COVERAGE STANDARD PLANS AND APPLICATION {January 1998}

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 - E

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.
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.
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.
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.

Plans issued through or in conjunction with a **Selective Contracting Arrangement:**

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):

1) Include only the **Schedule of Benefits** page which specifies the high deductible options. 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 - E, 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).