CHAPTER 21

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17B:27A–17 et seq., as amended by P.L. 1993, c.162.

Source and Effective Date

R.1993 d.553, effective October 15, 1993.
See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

Executive Order No. 66(1978) Expiration Date

Chapter 21, Small Employer Health Benefits Program, expires on October 15, 1998.

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SUBCHAPTER 1. GENERAL PROVISIONS

11:21–1.1 Purpose and scope

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

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

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

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

11:21–1.2 Definitions

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

"Act" means P.L. 1992, c.162 as amended by P.L. 1993, c.162, P.L. 1994, c.11, P.L. 1994, c.97, P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340 (N.J.S.A. 17B:27A–17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another, except that any insurance company, health service corporation, hospital service corporation, or medical services corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, hospital service corporation or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits Program established by the Act.

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in New Jersey.

"Cash deductible" means the amount of covered charges that a covered person must pay before the policy pays any benefits for such charges.

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

"Co-insured charge limit" means the amount of covered charges a covered person must incur before no co-insurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the co-insured charge limit.

"Co-payment" means a specified dollar amount a covered person must pay for specified covered charges.

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

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

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

"Doctor" means a medical practitioner who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

2. Provides medical services which are within the scope of the practitioner's license or certificate and which are covered by policies provided pursuant to this chapter.

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

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

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital or medical services corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group, pursuant to section 3 of the Act (N.J.S.A. 17B:27A–19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "Health benefits plan" excludes the following plans, policies, or contracts:

1. Accident only;

2. Credit;

3. Disability;

4. Long-term care;

5. Coverage for Medicare services pursuant to a contract with the United States government;

6. Medicare supplement;

7. Dental only;

8. Prescription only or vision only;

9. Insurance issued as a supplement to liability insurance;

10. Coverage arising out of a workers' compensation or similar law;

11. Hospital confinement or other supplemental limited benefit insurance coverage.

12. Automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.); and

13. Stop loss or excess risk insurance.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30–day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

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

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

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Pre-existing condition" means a policy or contract provision that excludes coverage under that policy or contract for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

"Primary care practitioner" means a network, or participating, provider who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology for those services only if applicable, or pediatrics, who supervises, coordinates, arranges and provides initial care and basic care medical services to a member; initiates a member's referral for specialist services; and is responsible for maintaining continuity of patient care.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of the Act and this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Act and this chapter which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer. For purposes of the Small Employer Health Benefits Act, a State, county or municipal body, agency, board or department shall not be considered a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan issued to small employers pursuant to N.J.S.A. 17B:27A–19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21–3.1, and set forth in the Appendix to this chapter.

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973, c.337 (N.J.S.A. 26:21–1 et seq.).

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

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $25,000 per covered person per plan year; and

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

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Added "Non-standard health benefits plan" and "Standard health benefits plan"; and amended "Act", "Commissioner", "Department", "Eligible employee", "Federally-qualified HMO", "Health benefits plan", "Small employer", "Small employer carrier", "Small employer health benefits plan", "State approved HMO", "Stop loss", and "Supplemental limited benefit insurance".

11:21–1.3 Communications with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

New Jersey Small Employer Health Benefits Program Board
20 West State Street
CN–325
Trenton, New Jersey 08625

New Rule, R.1993 d.644, effective November 12, 1993.
See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

11:21–1.4 Penalties

Failure of a carrier to comply with any provision of this chapter may result in the carrier losing its authority to write health benefits in New Jersey and imposition of any and all penalties and action available under law.

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

11:21–1.5 Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

Authority

N.J.S.A. 17B:27D–30, as amended by P.L. 1993, c.162, Section 16.

Source and Effective Date

R.1994 d.48, effective December 22, 1993.
See: 25 N.J.R. 4563(a), 26 N.J.R. 391(a).

11:21–2.1 Purpose and structure

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A–28) as amended by P.L. 1993, c.162, section 6 to assure the availability of the five standardized health benefits plans to New Jersey small employers, their eligible employees and the dependents of those eligible employees, on a guaranteed issue basis.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A–29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A–30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking

and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Thereafter, all public members of the Board shall be elected or appointed for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. No carrier shall have more than one representative on the Board.

(f) The following categories shall be represented among the elected public members:

1. Three carriers whose principal health insurance business is in the small employer market;

2. One carrier whose principal health insurance business is in the larger employer market;

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

5. Three persons representing small employers, at least one of whom represents minority small employers.

(g) The following categories shall be represented among the appointed public members:

1. Two insurance producers licensed to sell health insurance pursuant to N.J.S.A. 17:22A–1 et seq.;

2. One representative of organized labor;

3. One physician licensed to practice medicine and surgery in this State; and

4. Two persons who represent the general public and are not employees of a health benefits plan provider.

Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 27 N.J.R. 585(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Substantially amended (a); in (e), inserted "Of the two elected members... term of two years."; in (f)1, increased number from two to three; in (f)4, increased number from one to two; deleted (f)5 and (f)6, providing for risk-assuming carriers and reinsuring carriers; and recodified (f)7 as (f)5.

11:21–2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2 or as further defined below:

"Administrator" means that person or entity selected by the Board to effectuate the administrative functions of the Program.

"Board" means the Board of Directors of the Program. As used in this Plan, "Director" shall refer to a member of the Board.

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization ("HMO") authorized to issue health benefits plans in this State. For purposes of this Plan, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State or any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A–38 and N.J.A.C. 11:21–15.

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

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

"Earned premium" means the premium earned in New Jersey on health benefits plans less return premiums thereon.

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

"Health benefits plan" means any hospital and medical expense insurance policy or certificate, health, hospital, or medical service corporation contract or certificate, or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A–19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70, and stop loss or excess risk insurance.

"Member" means all carriers issuing health benefits plans in this State on or after the effective date of the Act.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer pursuant to the provisions of the Act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer. For purposes of the Small Employer Health Benefits Act, a State, county or municipal body, agency, board or department shall not be considered a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan issued to small employers pursuant to N.J.S.A. 17B:27A–19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21–3.1, and set forth in the Appendix to this Chapter.

"State" means the State of New Jersey.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of P.L. 1992, c.162 (N.J.S.A. 17B:27A–17 et seq.), the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $25,000 per covered person per plan year; and

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

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Reinsuring carrier" and "Risk-assuming carrier"; added "Non-standard health benefits plan", "Standard health benefits plan", and "Stop loss"; and amended "Board", "Commissioner", "Department", "Eligible employee", "Health benefits plan", "Member", "Small employer", "Small employer carrier", and "Small employer health benefits plan".

11:21–2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. Adopt rules and regulations to establish a voluntary risk pooling arrangement.

2. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

3. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

4. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the standard health benefits plans in accordance with applicable law;

5. Establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through the issuance of dual contracts to the small employer;

6. Promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under a group health insurance policy delivered or issued for delivery in this State shall conform to the form adopted by the Board and promulgated in conjunction with the Individual Health Coverage Program pursuant to P.L. 1993, c.162, Section 20;

7. Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

8. Establish rules, conditions, and procedures pertaining to the reimbursement and assessment of the members of the Program;

9. Establish a standard policy form for five standard health benefits plans and five rider packages, as provided in the Act;

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

11. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an Administrator or executive director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose advice or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the Board;

12. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

13. Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

14. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

15. Develop a buyers' guide for the Program, and provide for a reasonable charge for its use and distribution.

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

11:21–2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21–2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. The Board shall be made up of the Commissioner, the Commissioner of Health and Senior Services, or their designees (who shall serve ex officio) and 16 public members. The composition of the Board shall be as described in N.J.S.A. 17B:27A–29 as amended by P.L. 1994, c.97 and P.L. 1995, c.298. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in N.J.S.A. 17B:27A–29 as amended by P.L. 1994, c.97 and P.L. 1995, c.298.

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1995, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

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

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employer representatives nominated those persons that are eligible and willing to serve in the position for which nominated.

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

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

v. Elections shall be by the highest number of votes properly cast in person and absentee.

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:21–2.12.

3. The Board may elect a Chair, Vice Chair and Secretary from among its Directors, as well as other officers, as it deems appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A–29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) A meeting of the Board shall be held no later than the first Tuesday in April each year in accordance with the State's Open Public Meetings Act. At that meeting and/or subsequent meetings, the Board shall:

1. Review the financial results for the prior year, including expenses of Program administration and incurred losses, taking into account all other appropriate items; and

2. Determine if an assessment is necessary for the proper administration of the Program.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program, as recommended by the Marketing and Communications Committee;

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Legislature;

6. Fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably comprehensive minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent

with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4–12). At least two copies of the minutes of every meeting of the Board shall be delivered forthwith to the Commissioner.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services but may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and committee meetings pursuant to the State Travel Guidelines issued by the Department of the Treasury.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(*l*) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

(m) The affirmative vote of at least two-thirds of the Directors present at a meeting shall be required to authorize assessments and the expenditure of Program funds.

Amended by R.1994 d.319, effective May 31, 1994.
See: 26 N.J.R. 1940(a), 26 N.J.R. 2587(a).
Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 26 N.J.R. 4311(a), 27 N.J.R. 585(a).
Amended by R.1995 d.223, effective May 1, 1995.
See: 27 N.J.R. 438(a), 27 N.J.R. 438(b), 27 N.J.R. 1805(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, amended title of Commissioner and inserted additional P.L. references; in (a)2, inserted "Of the two elected members... term of two years."; in (a)2iv, added restriction on affiliated carrier Board membership; and in (b), amended titles of Commissioners.

11:21–2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board. A written record of the proceedings of each committee shall be maintained by a Secretary appointed from the membership of the committee. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and Operations Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;

iii. Establishment of rules, conditions, and procedures pertaining to the reimbursement of the members of the Program;

iv. Independent consulting actuaries who may be approved by the Board;

v. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and

vi. Oversight of studies necessary for development of reinsurance mechanisms;

vii. The Plan amendments thereto;

viii. The selection of an independent auditor for the annual audit of the Program operations;

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

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

xi. Developing the means to select a Program administrator, a statement of the powers and duties of the Administrator, the compensation of the Administrator, and a statement of the efficiency standards an Administrator must meet; and

xii. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an Administrator for the Program;

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

i. Appropriate interpretations of the Act, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

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

vi. Maintenance of a written record of all written requests for a formal opinion of the Board received and responses provided by the Board.

vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;

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

ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and

x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;

xi. Whether and how to respond to interpretations of the Board's rules made by carriers and inquiries and complaints received from consumers, policyholders, carriers or others.

(1) Recommendations by the Legal Committee may include a recommendation that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Legal Committee or Administrator may seek the input of other appropriate Committees in order to assist the Legal Committee in reaching a recommendation.

(3) The Legal Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

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

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

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

iii. Issues or concerns arising out of the marketing of Program coverage;

iv. The development of information concerning the Program to be released to the general public; and

v. Reviewing marketing material submitted by carriers in accordance with the Act; and

4. A Policy Forms Committee which shall make recommendations to the Board with respect to:

i. Optional benefit rider filings received pursuant to N.J.A.C. 11:21–3.2(d);

ii. Exhibit BB, Part 1 filings received pursuant to N.J.A.C. 11:21–4.2;

iii. Alternative method of utilization review filings received pursuant to N.J.A.C. 11:21–4.2;

iv. Modifications to the standard health benefits plan policy forms and related forms;

v. Interpretations of the standard health benefits plans and policy forms;

vi. Development of new standard health benefits plan policy forms as permitted by statute; and

vii. Substantive and structural plan design issues.

(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:

1. Determine the size of and appoint members to and/or fill any vacancy in any committee;

2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;

3. Abolish any committees, in its discretion;

4. Remove any person from membership on any committee at any time, with or without cause; and

5. Authorize or appoint the use of consultants or other advisors to work with any committee.

(d) All committee members, including those committee members who are not also members of the Board, shall be subject to the Small Employer Health Benefits Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D–12 et seq. Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and/or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Code of Ethics.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), increased maximum number of directors on Standing Committees from five to seven and inserted text "who need not be directors" following "appoint additional members"; substantially amended (b); and added (d).

11:21–2.7 Administrator selection and duties

(a) The Administrator shall be selected by the Board.

(b) The Administrator shall be selected by the Board in compliance with the public bidding law, N.J.S.A. 52:34–6 et seq.

(c) The Administrator shall perform the administrative functions required under the Act and the Plan. The Administrator is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.

(d) The Administrator shall perform all administrative functions developed by the Board including the following:

1. Preparing and submitting an annual report to the Board and the Commissioner no later than the third week of July; preparing and submitting monthly reports to the Board;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program on a timely basis in the State Treasury in an account established for that purpose;

6. Issuing checks or drafts, on and or approving charges against bank accounts of the Program;

7. Keeping all accounting, administrative and financial records of the Program;

8. Acting as a resource for carriers in complying with the Program;

9. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

10. Preparing an annual estimate of the operating and administrative expenses of the Program;

11. Preparing a detailed Operations and Procedures Manual which must include forms and procedures for processing business as required by the Plan; and

12. Performing other functions as agreed between the Board and the Administrator.

(e) The Administrator shall maintain calendar year records of premiums, reimbursements, and operating and administrative expenses and shall retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3–15 et seq.

(f) The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Reworded (d)5; deleted (d)6, relating to reimbursing reinsuring carriers; recodified (d)7 through (d)12 as (d)6 through (d)11; in (d)8, deleted reference to reinsuring carrier; deleted (d)13, relating to reviewing for compliance; and recodified (d)14 as (d)12.

11:21–2.8 Assessments for administrative and operating expenses

(a) Annually on or about July 15 the Board shall determine the final administrative expense total for the preceding calendar year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

3. Members shall be assessed for a proportionate share of the final administrative expenses on the basis of health benefits plan earned premiums for that year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the calendar year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members for the calendar year.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

(c) Assessment 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, SEH Program, c/o The New Jersey Department of Insurance, 20 W. State Street, CN–325, Trenton, NJ 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 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 amount has accrued, shall include the interest penalty amount accrued as of the invoice date; otherwise, payment shall not be considered to be in full.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board, shall be assessed 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 carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21–15.

i. 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 to be held in an interest bearing escrow account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The Administrator shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the Administrator until such time as the dispute has been settled against the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carrier within 15 days of the date that the Administrator receives notice of the determination by the Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

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

Amended by R.1997 d.62 effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), substituted "July 15" for "April 15".

11:21–2.9 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act.

Recodified from 11:21–2.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Assessment for reimbursable losses".

11:21–2.10 Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

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

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

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

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Any adjustments to assessments as explained in this Plan;

ii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

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

iv. Other records required by the Board.

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

6. The Board's fiscal year shall begin on July 1 and end on June 30.

7. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of Director of the Division of Budget and Accounting to the Program's bank accounts upon request by the Board through the Department.

3. The Administrator shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) A bank checking account and interest-bearing investment accounts shall be established separately in the name of the Program and shall be approved by the Board.

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

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program losses and administrative expenses.

Recodified from 11:21–2.11 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)4i, relating to net losses; recodified former (a)4ii through (a)4v as (a)4i through (a)4iv; inserted new (a)6; recodified former (a)6 as (a)7; in (b)2, deleted reference to including in the request justification for the request; and in (c), inserted reference to interest-bearing investment. Former section recodified to N.J.A.C. 11:21–2.9.

11:21–2.11 Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3–15–32) and all other applicable laws.

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

1. Minutes of all Board meetings;

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

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

4. Riders proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

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

7. Regulations or actions proposed or adopted by the Board, including all comments received; and

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

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right-To-Know" Act (N.J.S.A. 47:1A–1 et seq.) except that information in filings determined by the Board by regulation to be confidential and proprietary shall not be subject to public inspection and copying.

(d) For the purpose of disseminating information about the Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1–25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

Recodified from 11:21–2.12 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–2.10.

11:21–2.12 Audit functions

(a) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program; and

2. The annual fiscal report of the Program.

Recodified from 11:21–2.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a), relating to necessity and frequency of audits; recodified former (b) as (a); deleted (a)3, relating to calculation and collection of assessments for net losses. Former section recodified to N.J.A.C. 11:21–2.11.

11:21–2.13 Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board no later than 20 days after receiving the notice of assessment following the procedures in (d) below.

(d) Concurrent with its challenge to the assessment, a carrier shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and shall submit all documentation that supports or tends to support the carrier's position. The carrier shall also advise at this time whether a hearing is requested.

(e) If a hearing is requested, within 30 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the matter does not constitute a contested case, the Board shall review the challenge itself or delegate this review to an appropriate Committee to make a recommendation to the Board.

Recodified from 11:21–2.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–2.12.

11:21–2.14 Indemnification

(a) A member or employee of the Board, including the Administrator and staff, shall not be liable in an action for damages to any person for any action taken or recommendation made by him or her within the scope of his or her functions as a member or employee, if the action or recommendation was taken or made without malice.

(b) The members of the Board shall be indemnified and their defense of any action provided for in the same manner

and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L. 1972, c.45, on account of acts or omissions in the scope of their employment.

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–2.13.

11:21–2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

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

Recodified from 11:21–2.16 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Indemnification".

11:21–2.16 (Reserved)

Recodified to 11:21–2.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21–3.1 Benefits provided

(a) The standard 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, "The Small Group Health Benefits Basic Policy," Exhibit A;

2. Plan B, "The Small Group Health Benefits Policy B," Exhibit B and Exhibit F;

3. Plan C, "The Small Group Health Benefits Policy C," Exhibit C and Exhibit F;

4. Plan D, "The Small Group Health Benefits Policy D," Exhibit D and Exhibit F;

5. Plan E, "The Small Group Health Benefits Policy E," Exhibit E and Exhibit F;

6. Exhibit F contains those items of Plans B, C, D and E which are common among the plans;

7. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibit G; and

8. HMO/POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibit HH.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer all of the health benefits Plans A, B, C, D, and E as set forth in Exhibits A through F, in the Appendix, except as set forth in (c) below.

1. Plan A shall contain a deductible of $250.00 per covered person and:

i. $500.00 per covered family, to be satisfied by two separate covered persons and a per person coinsurance cap of $5,000; or

ii. $750.00 per covered family, to be satisfied on an aggregate basis and a person coinsurance cap of $5,000.

2. Plans B, C, and D shall contain the following annual deductible options to the small employer for each plan:

i. $250.00 per covered person and $500.00 per covered family; $500.00 per covered person and $1,000 per covered family; and $1,000 per covered person and $2,000 per covered family. For all three deductible options, the family deductible limit must be satisfied by two separate covered persons. The per person coinsurance caps for Plans B, C, and D are $3,000, $2,500, and $2,000 respectively. The family coinsurance caps for Plans B, C, and D are $6,000, $5,000, and $4,000 respectively, which must be satisfied by two separate covered persons; or

ii. $250.00 per covered person and $750.00 per covered family; $500.00 per covered person and $1,500 per covered family; and $1,000 per covered person and $3,000 per covered family. For all three deductible options, the family deductible limit must be satisfied on an aggregate basis. The per person coinsurance caps for Plans B, C, and D are $3,000, $2,500 and $2,000 respectively. The family coinsurance caps for Plan B, C, and D, are $9,000, $7,500, and $6,000 respectively, which must be satisfied on an aggregate basis.

3. Plan E shall contain a deductible of $150.00 per covered person and:

i. $300.00 per covered family, to be satisfied by two separate covered persons, with a per person coinsurance cap of $1,500, and a family coinsurance cap of $3,000 to be satisfied by two separate covered persons; or

ii. $450.00 per covered family, to be satisfied on an aggregate basis, with a per person coinsurance cap of $1,500, and a family coinsurance cap of $4,500 to be satisfied on an aggregate basis.

(c) State approved and Federally qualified HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $15.00 co-payment for all other co-payments. Prescription drugs may be subject to 50 percent coinsurance or $15.00 co-payment at HMO member's option. HMO members choosing to offer optional health benefits plans may offer one or more of the following co-payment options, provided that all options offered by the HMO member shall be offered to each small employer:

1. $75.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $5.00 co-payment for all other co-payments;

2. $100.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $10.00 co-payment for all other co-payments; and/or

3. $250.00 hospital inpatient co-payment excluding mental/nervous and substance abuse, $200.00 mental/nervous and substance abuse hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $20.00 co-payment for all other co-payments.

(d) The standard health benefits Plans B, C, D and E and optional riders may be offered through or in conjunction with an approved contracting arrangement approved pursuant to P.L. 1993, c.162, Section 22, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. The co-insured charge limit and deductibles specified for the standard health benefits plan being offered through or in conjunction with a managed care arrangement, as set forth in Exhibits B through G in the Appendix, shall be the co-insured charge limit and deductibles for the in-network and out-network benefits combined;

3. The HMO Plan standard co-payment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to in-network benefits. Where such co-payments are utilized, the applicable deductible and co-insured charge limit shall be applicable only to out-network benefits; and

4. Where in-network services are directed through a primary care physician under Plans B, C, D and E and HMO Plan, in-network services must conform to one of the options provided in (c) above, and out-network services must conform to one of the options provided in (b) above.

(e) The standard health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent co-insurance, the in-network benefit shall not be subject to co-insurance; and

2. For those services which are subject to 50 percent co-insurance, the in-network co-insurance shall be 30 percent.

(f) An insurer with an approved selective contracting agreement, like all other carriers, shall offer the standard health benefits plans, whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

1. If an insurer's approved service area for its selective contracting arrangement includes all geographic areas in the State, the insurer shall offer the standard health benefits plans as either indemnity plans or through or in conjunction with a selective contracting arrangement, or both, in all geographic areas in the State.

2. If an insurer's approved service area for its selective contracting arrangement does not include all geographic areas in the State, the insurer shall offer:

i. The standard health benefits plans as indemnity plans in all areas in the State not included in its approved service area; and

ii. The standard health benefit plans as either indemnity plans or in conjunction with a selective contracting

arrangement, or both in all geographic areas within its approved service area.

3. If an insurer with a limited approved service area chooses to offer the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(g) A carrier that is exempt from the requirements of P.L. 1993, c.162, section 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 shall offer the standard health benefits plans whether as indemnity plans or as PPO or POS plans in all geographic areas of the State.

1. If such a carrier has agreements with participating providers in all geographic areas of the State, the carrier shall offer the standard health benefits plans either as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State.

2. If such a carrier has agreements with participating providers only in certain geographic areas of the State, the carrier shall offer:

i. The standard health benefits plans as indemnity plans in all geographic areas of the State where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State where it has agreements with participating providers.

3. If such a carrier which has agreements with participating providers only in certain geographic areas of the State chooses to offer the standard health benefits plans only as PPO or POS plans in such areas and later expands the area in which it has agreements with providers, the carrier shall not be required to offer the standard health benefits plans as indemnity plans in the expanded area, but shall be required to renew the in force standard health benefits plans in the newly expanded area.

(h) State approved and Federally qualified HMO members may offer the HMO POS plan, as set forth in Exhibit HH of the Appendix, so long as the member is in compliance with N.J.A.C. 8:38–14, which regulations set forth requirements for HMOs offering indemnity benefits. HMO members offering the HMO POS plan may offer the following arrangements with respect to their in-network services and supplies:

1. $75.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only), $5.00 co-payment for all other co-payments, and prescription drugs at either a $5 co-payment or at the non-network Coinsurance level.

2. $100.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only), $10.00 co-payment for all other co-payments, and prescription drugs at either a $10 co-payment or at the non-network Coinsurance level.

3. $150.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only), $15.00 co-payment for all other co-payments, and prescription drugs at either a $15 co-payment or at the non-network Coinsurance level.

4. $250.00 hospital inpatient co-payment excluding mental/ nervous and substance abuse, $200.00 mental/nervous and substance abuse hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only), $20.00 co-payment for all other co-payments, and prescription drugs at either a $20 co-payment or at the non-network Coinsurance level.

Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), (d), and (e), substituted "standard health benefits plan" for "small employer health benefits plan"; added (a)8; in (d), deleted reference to HMO Plan; in (d)3, deleted reference to out-network benefits; and added (f) through (h).

11:21–3.2 Optional benefit riders to standard plans and administrative functions

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, or HMO plan, as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more standard optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select one or more of the following riders to be offered with each health benefits Plan (Plan B, C, D, or E):

i. Exhibit H, part 1 (mail order and card);

ii. Exhibit H, part 2 (card only); or

iii. Exhibit H, part 3 (mail order only).

2. Replacement mental and nervous conditions and substance abuse benefits, Exhibit I; and

3. Replacement prescription drug benefits for the HMO Plans. The carrier may select one or more of the following riders to be offered with the HMO health benefits plan:

i. Exhibit J, part 1 (mail order and card);

ii. Exhibit J, part 2 (card only); or

iii. Exhibit J, part 3 (mail order only).

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner pursuant to N.J.A.C. 11:21–12. No rider filed with the Commissioner may be sold until approved or deemed approved by the Commissioner.

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

3. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above includes, but is not limited to:

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

ii. Deductibles, Co-Insurance, Co-payments, Co-insured Charge Limits, and Co-Insurance Caps of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carryover, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent coverage" and "Continuation rights" sections of Plans A, B, C, D, and E, the "Eligibility" and "Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

4. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:21–1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and co-insurance or co-payment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:21–1.2.

5. Any rider containing dental benefits previously filed with the Board but which did not subject those benefits to the standard plan's deductible and co-insurance or co-payment schedule, as applicable, may no longer be issued or renewed as of January 1, 1996.

6. In addition to (d)1, 2, 3, 4, and 5 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9 and 11 of P.L. 1992, c.162.

7. A member making an informational filing to the Board pursuant to (d)2 above shall:

i. Submit an original one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21–1.3;

ii. Submit copies of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross-references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

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

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

v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

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

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

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

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

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:21–9; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the HMO POS contract, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4–37.3(b)6 and N.J.A.C. 8:38–14.4(c), as applicable.

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

i. If an informational filing is incomplete, but in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing.

ii. If an informational filing is incomplete and not in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is in substantial compliance or complete.

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

(e) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such arrangements shall not alter the standard group policy and certificate language.

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1995 d.116, effective March 6, 1995.
See: 26 N.J.R. 4729(a), 27 N.J.R. 918(a).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted "standard" preceding "optional benefits riders" and inserted reference to HMO POS throughout; in (a), inserted "standard" preceding "health benefits plan"; in (d)3i, added text "and the 'Covered Services and Supplies,' ... HMO POS plan"; in (d)3iii, inserted reference to Eligibility and Continuation Rights sections of the HMO POS plan; in (d)4ii and (d)5, deleted reference to vision coverage and benefits; in (d)7i, amended submission requirements and added (d)7vi(5).

SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

Authority

N.J.S.A. 17B:27A–17 et seq., as amended by P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340.

Source and Effective Date

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

Subchapter Historical Note

Subchapter 3A, Non-Standard Health Benefits Plan, was adopted by R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b). Subchapter 3A was repealed and a new Subchapter 3A, Non-Standard Health Benefits Plan, was adopted by R.1997 d.62, effective February 3, 1997. See: Source and Effective Date.

11:21–3A.1 Purpose and scope

This subchapter establishes the conditions under which non-standard health benefits plans may be issued, renewed or continued pursuant to P.L. 1995, c.340, and specifies the rules which shall apply to the issuance, renewal or continuation of a non-standard health benefits plan.

11:21–3A.2 Definitions

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

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board described at N.J.A.C. 11:21–3.1, and set forth in the Appendix to this chapter.

11:21–3A.3 Renewal of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall renew or continue a non-standard health benefits plan at the option of the small employer policy or contract holder, unless that plan is withdrawn by the carrier pursuant to N.J.A.C. 11:21–16, subject to the following:

1. The non-standard health benefits plan shall comply with the provisions of N.J.S.A. 17B:27A–18, 17B:27A–19b, 17B:27A–22, 17B:27A–23, 17B:27A–24, 17B:27A–25 and 17B:27A–27.

2. The non-standard health benefits plan shall comply with all applicable rating and loss ratio requirements, and shall comply with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. The non-standard health benefits plan, if issued by a carrier through an out-of-State trust:

i. Shall offer benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Shall be filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) A carrier, association, multiple employer arrangement or out-of-State trust shall not renew or continue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

11:21–3A.4 New issuance of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not issue a non-standard health benefits plan unless the non-standard health benefit plan:

1. Complies with the provisions of N.J.S.A. 17B:27A–18, 17B:27A–19b, 17B:27A–22, 17B:27A–23, 17B:27A–24, 17B:27A–25 and 17B:27A–27;

2. Complies with all applicable rating and loss ratio requirements, and complies with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. If issued by a carrier through an out-of-State trust:

i. Offers benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Is filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) An association, multiple employer arrangement or out-of-State trust may offer and issue a non-standard health benefits plan provided that the association, multiple employer arrangement, or out-of-State trust:

1. Shall offer and issue a non-standard health benefits plan to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust;

2. Shall offer or issue coverage only to a small employer that is or becomes a member of that association, multiple employer arrangement or out-of-State trust;

3. Shall not use actual or expected health status in determining its membership; and

4. Shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to any health benefits plans permitted to be renewed or continued pursuant to this subsection.

(c) A carrier may, but is not required to, issue to a small employer a non-standard health benefits plan that had been issued to the small employer by another carrier, so long as the replacing carrier has filed the health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(d) After January 5, 1996, a carrier may, but is not required, to issue a non-standard health benefits plan to a small employer through an association, multiple employer arrangement or out-of-State trust if the non-standard health benefits plan had previously been issued to a small employer by another carrier through the same association, multiple employer arrangement or out-of-State trust, so long as the replacing carrier files the non-standard health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner or the filing is deemed approved.

(e) A carrier, association, multiple employer arrangement or out-of-State trust shall not offer or issue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

11:21–3A.5 Mandatory offerings by carriers issuing non-standard plans

(a) A carrier offering a non-standard health benefits plan through any arrangement, including by or through an association, multiple employer arrangement or out-of-State trust, shall also offer the standard health benefits plans to any small employer.

(b) An association, multiple employer arrangement or out-of-State trust that offers a non-standard health benefits plan to its member's employees and dependents shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to the non-standard health benefits plan.

11:21–3A.6 Amendment of a non-standard health benefits plan

(a) Except as set forth in (b) below, a carrier may amend the benefits structure of a non-standard health benefits plan so long as:

1. The amendment does not reduce the actuarial value and the benefits coverage of the health benefits plan below that of the least comprehensive standard health benefits plan established by the Board; and

2. The amendment has been filed with the Commissioner for approval and the amendment has been approved or deemed approved.

(b) A carrier shall not modify the benefit structure of a non-standard health benefits plan in any way within six months of issuing the non-standard health benefits plan previously issued by another carrier directly to the small employer.

11:21–3A.7 Penalties

A carrier, association, multiple employer arrangement or out-of-State trust that violates any provision of this subchapter shall be subject to penalty and fines available under law.

SUBCHAPTER 4. POLICY FORMS

11:21–4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D and E which are set forth in the Appendix to this chapter as Exhibits A through F, subject to the "Explanation of Brackets (Plans A, B, C, D)" set forth in Exhibit K, Part 1 of the Appendix, incorporated herein by reference.

1. Notwithstanding (a) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A–17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21–1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit K, Part 2 of the Appendix, incorporated herein by reference.

1. Notwithstanding (b) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A–17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21–1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(c) Members shall use the standard policy form for HMO POS plan which is set forth in the Appendix to this chapter as Exhibit HH, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit JJ of the Appendix, incorporated herein by reference.

1. Notwithstanding (c) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A–17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21–1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(d) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21–3.2(c), members shall use the standard rider forms which are set forth in the Appendix to this chapter as Exhibits H, I, and J, as applicable.

(e) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(g) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(h) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets (HMO Plan)" set forth in Exhibit X, Part 2 of the Appendix, incorporated herein by reference.

(i) Members shall use the standard employee evidence of coverage for the HMO POS plan which is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets (HMO/POS Plan)" set forth in Exhibit JJ of the Appendix, incorporated herein by reference.

(j) Members shall use the Rider—Certificate Forms for Plans B, C, D and E as set forth in the Appendix to this chapter as Exhibit Z, Part 1, "Card/Mail"; Part 2, "Card"; Part 3, "Mail"; and Part 4 "Mental and Nervous Conditions and Substance Abuse Benefits."

(k) Members shall use the Riders—Employee evidence of coverage for HMO Plan as set forth in the Appendix to this chapter as Exhibit AA, Part 1, "Card/Mail"; Part 2, "Card"; and Part 3, "Mail."

(*l*) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted new (c); recodified former (c) through (g) as (d) through (h); in (d), inserted text "standard optional benefit"; added (i); and recodified former (h) through (j) as (j) through (*l*).

11:21–4.2 Certification or filing of forms

(a) No carrier shall issue any health benefits plan certificate or evidence of coverage to a small employer or the employees of a small employer or use any application form, employer or employee certification, waiver or enrollment form or make any amendments thereto until the carrier has certified that its health benefits plans and forms are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21–4 and 6.

1. A carrier shall submit completed Certification of Compliance forms, set forth in Part 1 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference upon entering the small employer market and on or before March 1 of each year thereafter.

2. A carrier shall submit completed Certification of Compliance forms to the Board, in triplicate, at the address set forth at N.J.A.C. 11:21–1.3, and one copy to the Commissioner at the following:

Attn: SEH Form Certification of Compliance
Office of Life and Health Actuaries
New Jersey Department of Banking and Insurance
20 West State Street
CN 325
Trenton, NJ 08625–0325

3. Certification of Compliance forms shall be certified by a duly authorized officer of the carrier.

(b) A carrier that elects to include in its health benefits plans an alternative method of utilization review shall submit, in addition to the required Certification of Compliance, its alternative method of utilization review to the Board as specified at N.J.A.C. 11:21–4.1 with copies submitted to the Commissioner as set forth in (a)2 above.

(c) As a condition of approval, all alternate methods of utilization review provisions shall contain the statement that the utilization review modifies the small employer health benefits policy form language and has been approved for use by the carrier pursuant to N.J.A.C. 11:21–4.3. As a condition of approval, all combined form policies shall contain a statement that together, the two policies provide coverage as specified in N.J.A.C. 11:21–3.1, and have been approved pursuant to the requirements of N.J.A.C. 11:21–4.3.

(d) Any amendment to an approved alternative method of utilization review shall be submitted to the Board and simultaneously to the Commissioner for review and approval as set forth in (b) above.

(e) Carriers that submit Certification of Compliance forms may issue and make effective small employer health benefits plans upon filing such forms with the Board and the Commissioner, or January 1, 1994, whichever date is later, and may continue to do so until such time as the filing is disapproved in writing by the Board (in consultation with the Commissioner), following an opportunity for a hearing held in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and any rules promulgated thereunder.

(f) Notwithstanding (e) above, a carrier shall neither issue nor make effective any health benefits plan to which an alternative method of utilization review or amendment thereto will apply until approved by the Board in consultation with the Commissioner.

(g) All forms to be used by a hospital service corporation and another carrier in conjunction in order to offer the small employer health benefits plans pursuant to N.J.S.A. 17B:27A–19e shall be submitted simultaneously to the Board and the Commissioner, and shall not be used until approved by the Board in consultation with the Commissioner.

1. Forms shall be submitted in triplicate as set forth in (a)2 above.

2. Carriers shall submit a certification of substantial compliance and a description of the differences between the combined forms and the forms promulgated by the Board. The certification of substantial compliance shall be certified by a duly authorized officer of each of the carriers.

3. The Board shall notify the small employer carriers in writing within 60 days of receipt by the Board and the Commissioner of a completed submission, whether the combined forms are approved.

4. The small employer carriers shall have a right of appeal if the Board, in consultation with the Commissioner, disapproves the combined forms, in accordance with procedures established by the Board in its Plan of Operation.

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (a)2, and (c), amended submission requirements.

11:21–4.3 Standards for review

(a) In determining whether to approve an alternative method of utilization review or combined forms (of a hospital service corporation and another small employer carrier), a carrier shall consider in submitting in its Certification of Compliance (with respect to an alternative method of utilization review), and its certification of substantial compliance (with respect to combined forms), and the Board and Commissioner shall consider in their review whether:

1. The inclusion of words, terms and descriptions that are not contained in the Board's forms changes the meaning or effect of any material aspect of the small employer health benefits plans and other attendant Board forms;

2. The alternative method of utilization review or combined forms contain all provisions required by New Jersey law and the small employer health benefits plans forms which, if not the same as that required by law or in the small employer health benefits plans forms, is at least as favorable to the covered person;

3. The alternative method of utilization review or combined forms contain all coverages, coverage limits and exclusions set forth in the small employer health benefits plans forms;

4. There is any deviation from the effective date of coverage, renewal or termination provisions in the small employer health benefits plans forms; and

5. Easy comparison with the appropriate small employer health benefits plans forms by the consumer, the Board or the Commissioner is impeded.

(b) In addition to (a) above, the Board, in consultation with the Commissioner, may disapprove an alternative method of utilization review or combined forms on the grounds that its provisions are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).

11:21–4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21–4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. The Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form, HMO or HMO POS contract, certificate, evidence of coverage or standard rider which has incorporated board promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21–4.1, Members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by (a) and (b) above. In no event shall the Compliance and Variability Rider be used in lieu of optional benefit riders which riders are subject to filing requirements set forth in N.J.A.C. 11:21–3.2(d).

New Rule, R.1995 d.312, effective June 19, 1995.
See: 27 N.J.R. 439(a), 27 N.J.R. 2407(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted references to HMO POS contracts throughout.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:21–5.1 Standard claim form

(a) All members offering health benefits plans to small employers, 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 claim forms approved by the Board and set forth in Exhibit L in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions, set forth in Exhibit L, Part 1, 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 L, Part 2, shall be the standard claim form for all hospital inpatient services.

(b) If a carrier determines that additional information is necessary of the claimant to process a claim, the carrier shall use the "Annual Family Profile and Claim Notice" form as set forth as Exhibit M and incorporated herein by reference. A carrier shall not use any other form to solicit family profile information of the claimant.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted reference to electronic billing system and amended UB form reference.

SUBCHAPTER 6. STANDARD EMPLOYER AND EMPLOYEE APPLICATION AND SMALL EMPLOYER CERTIFICATION FORMS

Authority

N.J.S.A. 17B:27A–17 et seq., amended by P.L. 1993, c.162, section 16 and N.J.S.A. 52:14B–4(f).

Source and Effective Date

R.1993 d.644, effective November 12, 1993.
See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a).

11:21–6.1 Standard application form

(a) All small employer carriers offering small employer health benefits plans with an effective date on or after January 1, 1994, shall use the standard application form approved by the Board and specified in Exhibit N of the Appendix to this chapter incorporated herein by reference.

(b) Small employer carriers shall require any small employer applying for a small employer health benefits plan to be issued by that small employer carrier to complete, as part of the application, the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference.

11:21–6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference. This form shall be sent to the small employer for completion no earlier than 120 days prior to the renewal of the small employer's health benefits plan.

11:21–6.3 Enrollment

(a) Small employer carriers shall require each eligible employee electing coverage under the small employer health

benefits plan to complete the Enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election.

(b) Small employer carriers offering the HMO plan and the HMO POS plan shall require each eligible employee electing coverage under the HMO plan to complete the enrollment form approved by the Board and specified in Exhibit R of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election.

(c) A small employer carrier may require a report of an eligible employee's health status for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act. The carrier shall require eligible employees to complete the Health Status form approved by the Board and specified in Exhibit S of the Appendix to this chapter incorporated herein by reference.

1. Beginning on September 11, 1994, such report may be used only for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act.

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted reference to HMO POS plan.

11:21–6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference. The waiver form may be combined with Exhibit Q, into a single form, at the option of the carrier without modification of the content of either form, except to reformat in any manner necessary to simplify administration.

SUBCHAPTER 7. PROGRAM COMPLIANCE

Authority

N.J.S.A. 17B:27A–17 et seq., amended by P.L. 1993, c.162, section 16 and N.J.S.A. 52:14B–4(f).

Source and Effective Date

R.1993 d.644, effective November 12, 1993.
See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a).

11:21–7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees on or after January 1, 1994.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

11:21–7.2 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21–1.2 or as further defined below, unless the context clearly indicates otherwise.

"Affiliated company" means any corporation which is a member of a controlled group of corporations; organization under common control with the small employer; organization which is included with the small employer in an affiliated service group; or other entity required to be aggregated with the small employer, all in accordance with sections 414 and 1563 (without regard to sections 1563(a)(4) and (e)(3)(c)), of the Internal Revenue Code of 1986, as amended.

"Non-standard health benefits plan" means only a health benefits plan that was issued to cover one or more small employers by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Qualifying previous coverage" means benefits or coverage provided under:

1. Medicare or Medicaid or any other Federally funded health benefits program;

2. A group health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, or an employer-based, self-funded, or other health benefit arrangement; or

3. An individual health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization.

Qualifying previous coverage shall not include the following policies, contracts or arrangements, whether issued on an individual or group basis: specified disease only, accident only, credit, disability, long-term care, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, stop loss or excess risk insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C.39:6A–1 et seq.).

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Health benefits plan" and "Standard health benefits plan"; and added "Qualifying previous coverage.

11:21–7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21–3A with respect to non-standard health benefits plans, a small employer carrier shall issue a health benefits plan to any small employer which requests it, pays the premiums therefor and meets the contribution and participation requirements, if any, of the small employer carrier. All health benefits plans shall provide coverage for all eligible employees and their dependents who elect to participate regardless of their health and without exclusionary riders.

1. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographic location of the small employer, except that small employer carriers that are HMOs may refuse to issue coverage to a small employer not physically located in the HMO's service area.

2. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographical location of the employees of the small employer, except that:

i. The small employer carrier shall refuse to issue coverage to an employer if the majority of its eligible employees are not employed within the State of New Jersey; or

ii. The small employer carrier may refuse to issue coverage if the participating employees are not physically located within the small employer carrier's service area, if the small employer carrier is an HMO.

3. Every small employer carrier, except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers the five standard health benefits plans, including all riders it writes, except as such riders may be restricted to specific standard health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to small employers every standard health benefits plan it writes, including all riders it writes, except as such riders may be restricted to specific standard health benefits plans.

4. A small employer carrier shall consider the number of all eligible employees of all affiliated companies of a small employer in determining whether an employer is a small employer and in determining participation levels.

5. At the time of application, the determination of whether an employer is a small employer shall be based upon the small employer's completed New Jersey Small Employer Certification form.

i. If an employer qualifies as a small employer in the immediately preceding calendar quarter, the employer shall be considered a small employer regardless of the status of the employer on the date of application or the effective date of coverage.

ii. If an employer did not qualify as a small employer in the immediately preceding calendar quarter, the employer shall not be considered a small employer, regardless of the status of the employer on the date of application or the proposed effective date of coverage, if any, except as set forth in (a)5iii below.

iii. If an employer did not qualify as a small employer in the immediately preceding calendar quarter because the employer was not in existence in the prior calendar quarter, the employer shall be considered a small employer if, on the date of application, the employer has between two and 49 eligible employees, the majority of whom are working in the State. Carriers may request appropriate documentation from a group to verify that the group is a bona fide small employer.

(b) Except as otherwise provided in N.J.A.C. 11:21–3A with respect to the issuance of non-standard health benefits plans, a small employer carrier shall issue only standard health benefits plans to an association, trust or multiple employer arrangement to provide coverage to member small employers or to two or more eligible employees of a member small employer.

1. No carrier shall issue a health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every health benefits plan issued to the association.

(c) In determining an employer's number of eligible employees, a small employer carrier shall consider in the calculation the number of independent contractors that the employer may include on its application for coverage to the extent that each independent contractor:

1. Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration;

2. Is working exclusively for the employer;

3. Works 25 or more hours per week for the employer;

4. Works on other than a temporary or substitute basis; and

5. The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage.

(d) Employees who enroll within 30 days of first becoming eligible for coverage shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to their risk characteristics or that of their dependents, except that a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21–7.8.

(e) A small employer carrier may elect to provide coverage to a small employer's part-time employees (that is, working fewer than 25 hours per week), if the small employer covered part-time employees under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all part-time employees of all such small employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts.

2. Such covered employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(f) A small employer carrier may elect to provide coverage to a small employer's retired employees, if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all retired employees of all such employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts; and

2. Such covered retired employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(g) A small employer carrier may elect to provide coverage to retired employees and/or part-time employees of an employer that becomes a small employer subsequent to January 1, 1994, if the employer covered retired and/or part-time employees under a group health plan issued prior to January 1, 1994, under a health benefits plan renewed or reinstated by the carrier in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or a standard health benefits plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 and (f)1 and 2 above.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a); in (b), amended N.J.A.C. reference; and in (e), (f), and (g), substituted P.L. reference for N.J.A.C references.

11:21–7.4 Restrictions on replacement of health benefits plans

(a) A small employer who purchases a health benefits plan or rider pursuant to the Act shall not be permitted to purchase a health benefits plan or rider with a greater actuarial value until the first anniversary date of the small employer's existing health benefits plan.

(b) When a small employer replaces a health benefits plan or rider with a health benefits plan or rider of greater actuarial value, the small employer shall not be permitted to change the health benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's health benefits plan.

(c) A small employer who has purchased a health benefits plan or rider pursuant to the Act may purchase a health benefits plan or rider of lesser actuarial value prior to the anniversary date of the existing health benefits plan or rider, provided that the existing health benefits plan or rider was purchased at least 12 months prior to the latest anniversary date of the health benefits plan or rider.

(d) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may:

1. Refuse to issue a health benefits plan to the small employer group for one year from the last date of coverage of the previous plan; or

2. Require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

Recodified from 11:21–7.5 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "standard" "preceding health benefits plan" throughout. Section was "Carriers acting as administrators for small employers".

11:21–7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who either:

1. Is covered under any health benefits plan offered by the small employer; or

2. Is not covered under the small employer's health benefits plan because the employee is covered as a dependent under a spouse's health benefits policy or contract, as long as the spouse's plan is not an individual health insurance policy or contract but is otherwise included in the definition of qualifying previous coverage.

(b) A small employer carrier may, upon approval by the Board, require a minimum participation of less than 75 percent provided that the small employer carrier:

1. Notifies the Board in writing of its minimum requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser participation requirements, in accordance with procedures established by the Board in its Plan of Operation.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Recodified from 11:21–7.6 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a). Former section recodified to N.J.A.C. 11:21–7.4.

11:21–7.6 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers.

(b) A small employer carrier may, upon approval of the Board, require a minimum contribution of less than 10 percent provided that the small employer carrier:

1. Notifies the Board in writing of its contribution requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser contribution requirements, in accordance with procedures established by the Board in its Plan of Operation.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21–7.7 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.5.

11:21–7.7 Preexisting condition standards

(a) A health benefits plan of a small employer with five or fewer eligible employees, as determined on the effective date of each subsequent policy anniversary, shall not deny, exclude or limit benefits, for a covered individual for losses incurred more than 180 days following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition is an illness or injury which manifests itself in the six months before a covered individual's coverage under the health benefits plan becomes effective and for which: the individual received medical care, treatment or took prescribed drugs; or, an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the individual's coverage starts. A pregnancy which exists on the date an individual's coverage becomes effective is also a preexisting condition.

(b) A small employer carrier shall waive any time period applicable to a preexisting condition limitation period for the period of time an individual was covered under any qualifying previous coverage that provided benefits with respect to such condition, provided that the qualifying previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied under the terms of the health benefits plan.

(c) The standards set forth in (a) and (b) above shall also apply to a late enrollee under a health benefits plan, unless ten or more late enrollees request enrollment during any 30 day enrollment period.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.8 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.6.

11:21-7.8 Effective date of coverage

(a) A small employer carrier, prior to issuing a health benefits plan, may require the following:

1. A completed small employer standard application form including the small employer certification form in accordance with N.J.A.C. 11:21-6.1(a) and (b);

2. Complete employee enrollment material in accordance with N.J.A.C. 11:21-6.3 and 6.4; and

3. An advance premium payment not to exceed one month's premium, except as provided in N.J.A.C. 11:21-7.5(d)2, which shall be refunded to the employer if the health benefits plan is not issued by the small employer carrier.

(b) A small employer carrier shall provide notice to the employer within 15 working days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employer's application for the health benefits plan. If approved, the effective date of coverage under the health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c) At the option and upon the request of the small employer, a waiting period may be applied by the small employer carrier with respect to employees when they first become eligible for coverage, not to exceed six months. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(d) A small employer carrier may offer an automatic checking withdrawal option to small employer groups for the monthly or quarterly payment of premiums. In the event that a small employer carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all small employer groups, regardless of the size of the group or the type of health benefits plan.

(e) A small employer carrier may require that its small employer groups make monthly or quarterly premium payments through an automatic checking withdrawal option. In the event that a small employer carrier elects to require that its small employer groups pay premiums through an automatic checking withdrawal option, the small employer carrier shall apply this requirement to every small employer group, regardless of the size of the group or the type of health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.9 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.7.

11:21-7.9 Price quotes; disclosures

(a) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized producer, within 10 working days of receiving a request for a quote and such information as is reasonable and necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(b) Each small employer carrier shall make reasonable disclosure in price quotes provided to small employers of the provisions concerning the small employer carrier's right to change premiums and the criteria in the small employer carrier's rate filing which affect changes in premium rates.

Recodified from 11:21-7.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.8.

11:21-7.10 Tie-ins

A small employer carrier shall not require, as a condition to the offer or sale of a health benefits plan to a small employer, that the small employer purchase or qualify for any other insurance products or services.

Recodified from 11:21-7.11 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.9.

11:21-7.11 Guaranteed renewal; notice of non-renewal

(a) All health benefits plans that are issued or renewed on or after January 1, 1994, must be guaranteed renewable at the option of the small employer, except for the following reasons:

1. Nonpayment of required premiums;

2. Fraud or misrepresentation with respect to coverage of eligible employees or dependents or status as a small employer;

3. The number of employees covered under the health benefits plan is less than the percentage of eligible employees required by participation requirements under the plan;

4. The small employer is no longer a small employer. The determination as to the small employer's status as a small employer shall be made at the anniversary date of the small employer's health benefits plan, in accordance with N.J.A.C. 11:21-7.3(a)5;

5. Noncompliance with a small employer carrier's employer contribution requirements;

6. A small employer ceases its membership in an association or trust of employers where the health benefits plan was issued in connection with such membership; or

7. The small employer carrier institutes a withdrawal in accordance with N.J.S.A. 17B:27A–23e and rules promulgated thereunder by the Commissioner.

(b) Effective January 5, 1996, if a small employer is no longer eligible for coverage, a small employer carrier shall notify a small employer, in writing, at least 60 days prior to the termination of the policy or contract, except if termination is for one of the following:

1. Nonpayment of required premiums by the policy or contract holder or employer;

2. Fraud or misrepresentation of the policy or contract holder or employer; or

3. With respect to coverage of eligible employees or dependents, fraud or misrepresentation of the enrollees or their representatives.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21–7.12 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)6, relating to coverage for less than two employees; recodified (a)7 and (a)8 as (a)6 and (a)7; and added (b). Former section recodified to N.J.A.C. 11:21–7.10.

11:21–7.12 Reporting requirements

(a) Effective January 1, 1995, a small employer carrier shall file with the Board annually no later than March 15, the following information reported separately with respect to standard and non-standard health benefits plans:

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar year, separately as to newly issued plans and renewals, and separately for standard health benefits plans A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

2. The number of health benefits plans in force by geographic territory, labeled A through F, as set forth in N.J.A.C. 11:21–7.14, and by two digit Major Group of the Standard Industrial Classification as of December 31 of the previous calendar year;

3. The number of health benefits plans that were voluntarily cancelled by small employers in the previous calendar year;

4. The number of health benefits plans that were cancelled or nonrenewed by the carrier in the previous calendar year, and the reason for such cancellation or nonrenewal; and

5. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar year that were uninsured for at least the three months prior to issue.

(b) Effective on the first fiscal quarter ending on September 30, 1994, a small employer carrier shall file with the Board, quarterly no later than 45 days after the end of the fiscal quarter, the following information reported separately with respect to standard and non-standard health benefits plans:

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter, reported separately as to newly issued plans and renewals, and separately for standard health benefits plans A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately for each standard health benefits plan A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

3. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter and were uninsured for at least the three months prior to issue.

(c) Annual and quarterly reports shall be filed at the address listed in N.J.A.C. 11:21–1.3.

(d) In lieu of submission on paper, a small employer carrier is encouraged to submit the reports required by this subsection on a 3.5 inch 1.44 MB computer disk, which provides the information in the format set forth in (a) and (b) above, and includes instructions for the use of the program, which pre-formatted disk is available upon request from the SEH Program at the address listed in N.J.A.C. 11:21–1.3.

(e) An insurance company, health service corporation, hospital service corporation, or medical service corporation and affiliated health maintenance organization shall file separate reports.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21–7.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (b)1, and (b)2, inserted reference to plans sold through selective contracting and to HMO POS; in (a)2, substituted reference to geographic territory for reference to three digit zip code and amended N.J.A.C. reference; and added (d) and (e).

11:21–7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay

covered charges on a reasonable and customary standard based on the Prevailing Healthcare Charges System profile for New Jersey, incorporated herein by reference published and available from the Health Insurance Association of America, 1025 Connecticut Avenue, NW, Washington, D.C. 20036–3998.

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

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

Recodified from 11:21–7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.12.

11:21–7.14 Permissible rate classification factors

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

1. Age factor categories shall be limited to the following increments: 24 and under; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70 and over.

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

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

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

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

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

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

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

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E or HMO, on the basis of family structure according to only the following four rating tiers:

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

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

11:21–7.15 (Reserved)

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

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

Authority

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

Source and Effective Date

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

Subchapter Historical Note

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

11:21–7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of N.J.S.A. 17B:27A–19.3 and 25.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted a reference to N.J.S.A. 17B:27A–19.3 and 25 for a reference to the Act.

11:21–7A.2 Definitions

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

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

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

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

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard benefits plan" and "Open nonstandard health benefits plan"; and deleted "Total employee months exposed".

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

(a) Each carrier having the five standard health benefits plan policy forms, open or closed nonstandard health benefits plan policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference. The annual loss ratio report, beginning with 1997 data reported in 1998, shall:

1. Aggregate standard health benefits plans, including all standard and nonstandard riders thereto;

2. Aggregate open nonstandard health benefits plans, including all riders and endorsements thereto; and

3. Aggregate closed nonstandard health benefits plans including all riders and endorsements thereto.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year.

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

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

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a); and in (b), deleted exception at the end of the sentence.

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

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

1. The reporting carrier's name and address;

2. The carrier's earned premiums, before dividends or credits applicable to prior years, and claims for the preceding calendar year, calculated pursuant to the instructions of Exhibit GG;

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

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

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

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

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

8. Such other information as the Department may request.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (a)2, substituted a reference to dividends for a reference to refunds, and added ", calculated pursuant to the instructions of Exhibit GG" at the end.

11:21–7A.5 Dividend or credit plan

(a) If the preceding calendar year loss ratio for any of the classifications listed in N.J.A.C. 11:21–7A.3(a) is less than 75 percent, the carrier shall include within the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that classification in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 75 percent of the premiums for that classification in the preceding calendar year.

1. Carriers that issue health benefits plans through out-of-State trusts, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

(b) The experience for all standard health benefits plans shall be combined for dividend purposes.

(c) The experience for all open nonstandard health benefits plans shall be combined for dividend purposes. Open nonstandard health benefits plans shall not be combined with any standard health benefits plans or closed nonstandard health benefits plans.

(d) The experience for all closed nonstandard health benefits plans shall be combined for dividend purposes. Closed nonstandard health benefits plans shall not be com-

bined with any standard health benefits plans or open nonstandard health benefits plan.

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

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

(g) All dividends and credits shall be distributed by December 31 of the reporting year.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a) through (c); inserted a new (d); recodified former (d) through (f) as (e) through (g); in (e), substituted a reference to small employers for a reference to policyholders; in (f), substituted a reference to dividends and credits for a reference to refunds; and rewrote (g).

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON–MEMBER STATUS

Authority

N.J.S.A. 17B:27A–17 et seq., as amended by 17B:27A–51.

Source and Effective Date

R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

11:21–8.1 Purpose and scope

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

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

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

11:21–8.2 Definitions

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

"Group health benefits plan" means a hospital and medical expense insurance policy, a health service corporation subscriber contract, a hospital service corporation subscriber contract or a health maintenance organization enrollment contract issued to a small employer. A group health benefits plan includes, but is not limited to, a health benefits plan. A group health benefits plan excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers compensation or similar law, automobile medical payment insurance or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.) and stop loss or excess risk insurance.

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

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

11:21–8.3 Non-member status

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

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

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

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

Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.

11:21–8.4 Non-member certification requests

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

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

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

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21–8.3.

11:21–8.5 Decisions on filings by the Board

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

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

11:21–8.6 Review

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

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

(c) Within 30 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted. If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

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

Authority

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

Source and Effective Date

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

11:21–9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to N.J.S.A. 17B:27A–17 et seq.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to N.J.S.A. 17B:27A–17 et seq.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted references to N.J.S.A. 17B:27A–17 et seq. for references to the Act throughout.

11:21–9.2 Definitions

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

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

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

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

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

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

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

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

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

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

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard health benefits plan" and "Open nonstandard health benefits plan"; and rewrote "Nonstandard health benefits plans".

11:21–9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993

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

1. A plan schedule for each of the standard health benefits plans and nonstandard health benefits plans offered, outlining:

i. The benefit options available;

ii. The delivery system(s) for each plan;

iii. The in-network and out-of-network coinsurance percentages and/or copays for selective contracting arrangements or HMO point-of-service arrangements;

iv. The benefit differential for each nonstandard rider offered, separately specifying benefit increases and benefit decreases;

v. The basic premium rates or rating factors applicable for each option including the difference when Medicare is primary or secondary, which must be based on actual employee or spouse Medicare coverage status; and

vi. The coverage period, if any, for which the rates for a group are guaranteed;

2. A rate manual containing:

i. The numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of the covered persons in accordance with N.J.A.C. 11:21–7.14;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates set forth pursuant to (a)1v above into the rates charged to a small employer group;

iii. A detailed example calculation, in the proposal format used by the carrier, for any one plan including a rider or POS option, showing all of the steps to develop premiums for a small group and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State; and

iv. A specification of the rule, which must be invariable, stating if the issue rate is based on the issue enrollment or the proposal rate.

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

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

ii. The assumptions used in developing the anticipated loss experience and the basic premium rates specified in (a)1v above, and the anticipated distribution of business by rating classification described in (a)2 above;

iii. A statement whether or not the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A–25g(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 3iv(4), 3iv(5) or 3iv(6) below, as appropriate;

iv. A certification signed by a member of the American Academy of Actuaries attesting as follows:

(1) The filing is accurate and complete and complies with the provisions of this subchapter;

(2) The issue period for which the filed rates are applicable, which period shall not exceed 12 months;

(3) The anticipated incurred loss ratio for each plan, which shall not be less than 75 percent of the premium therefor;

(4) For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996, that the rating methodology will not provide rates (for an individual and for each family status) for the highest rated group in this State which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group in this State for each plan and option;

(5) That rates to be charged to any group do not vary based on any classification factor other than those permitted in (a)2ii above; and

(6) Whether the rates for the Open Nonstandard and Closed Nonstandard plans are on the same or a different basis as the rates for the Standard plans and, if different, the average percentage relationship to the Standard plan basis; and

v. A certification that the actuarial memorandum contains confidential and proprietary information, if it is the actuary's belief that it does.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan (including any standard or nonstandard rider option after September 11, 1994), an open nonstandard health benefits plan or a closed nonstandard health benefits plan, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above.

1. Carriers that issued or renewed open nonstandard health benefits plans or closed nonstandard health benefits plans prior to the effective date of this amendment shall have until 90 days following the effective date of this amendment within which to come into compliance with this subchapter.

(c) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above.

(d) In addition to meeting the requirements of (a) through (c) above, an informational rate filing shall not be considered complete unless the plan schedule and rate manual meet the following format requirements:

1. Each page shall contain the name of the carrier for which the filing is made;

2. Each page shall be distinctively numbered;

3. If future filings may be made by way of replacement pages only, then each page shall be dated clearly and distinctively; and

4. In all instances, there shall be a table of contents which shall include the date of the most recent filing, and shall include the date(s) of the respective pages when filings are made by way of replacement page.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the section.

11:21–9.4 Informational filing procedures

(a) Informational filings submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Informational Rate Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 60 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21–9.3. If the Commissioner takes no action with respect to the informational filing within 60 days of the date of submission thereof, the information filing shall be deemed complete.

(c) If the informational filing is incomplete but in substantial compliance with the requirements of N.J.A.C. 11:21–9.3, the carrier shall, within 30 days of receipt of written notice in (b) above, provide the Commissioner with the information required to complete the filing. Failure on the part of the carrier to comply with the provisions of this subsection may result in the imposition of a penalty pursuant to N.J.A.C. 11:21–9.6.

(d) If the informational filing is incomplete and not in substantial compliance with the requirements of N.J.A.C. 11:21–9.3, the Commissioner shall provide written notice to

the carrier specifying the portions of the filing which are deficient and the information required to be submitted by the carrier. Upon receipt of notice from the Commissioner that the filing for any health benefits plan is not in substantial compliance, no contract, policy or certificate shall be entered into or renewed using the submitted rates until the Commissioner has determined that the informational filing is in substantial compliance or complete, and has provided written notice of that fact to the carrier. If the Commissioner takes no action within 30 days of the carrier's submission of information in an effort to render the filing in substantial compliance, the filing shall be deemed to be in substantial compliance.

(e) Any carrier aggrieved by a determination of the Commissioner pursuant to (b), (c) or (d) above may request a hearing on the Commissioner's determination, within 20 days of the receipt of notice of such determination, as follows:

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

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

ii. A copy of the notice involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

2. The hearing shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (b), increased periods for providing written notice and taking action from 30 to 60 days.

11:21–9.5 Public disclosure of filed information

(a) All data or information filed with the Department pursuant to N.J.A.C. 11:21–9.3(a) are public records and may be disclosed in accordance with N.J.S.A. 47:1A–1 et seq., except that actuarial memoranda which contain confidential and proprietary information pursuant to N.J.A.C. 11:21–9.3(a)3 shall not be disclosed by the Department to any person other than employees and representatives of the Department.

(b) A carrier shall separately identify in all informational rate filings the confidential actuarial information from all other information required by this regulation. If not so identified, all information shall be considered public information and subject to disclosure.

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

11:21–9.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey.

SUBCHAPTER 10. THE MARKET SHARE REPORT

Authority

N.J.S.A. 17B:27A–17 et seq., as amended by 17B:27A–51.

Source and Effective Date

R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

11:21–10.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

(b) This subchapter shall apply to all carriers that are, or become, members of the SEH Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member on the report filing due date.

11:21–10.2 Definitions

Words and terms used in this subchapter shall have the following meanings as set forth in the Act or the chapter, unless otherwise defined below, or the context clearly indicates otherwise.

"Group health benefits plan" means a hospital and medical expense insurance policy, a health service corporation subscriber contract, a hospital service corporation subscriber contract or a health maintenance organization enrollment contract issued to a small employer. A group health benefits plan includes, but is not limited to, a health benefits plan. A group health benefits plan excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers compensation or similar law, automobile medical payment insurance or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.)

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

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

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

Authority

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

Source and Effective Date

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

11:21–19.1 Purpose and scope

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

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

11:21–19.2 Definitions

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

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

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

11:21–19.3 SEH Program premium comparison survey

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

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

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

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

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

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

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

11:21–19.4 Penalties

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

APPENDIX

EXHIBIT A

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 1998]

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

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

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

POLICY INDEX

SECTION	PAGE(S)
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General Provisions	
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SCHEDULE OF INSURANCE AND PREMIUM RATES **PLAN A**

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

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:

•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment

-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:

•for Preventive Care	None
•for Facility charges made by:	
-a Hospital	20%
-an Ambulatory Surgical Center	20%
-a Birthing Center	20%
-an Extended Care Center or Rehabilitation Center	20%
-a Hospice	20%
•for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
-Prescription Drugs	20%
-Blood Transfusions	20%
-Infusion Therapy	20%
-Chemotherapy	20%
-Radiation Therapy	20%
• for all other Covered Charges	50%

Coinsurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

•During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi- private room and board rate.

For private room and board accommodation, [Carrier] will cover charges up to the Hospital's average daily semi- private room and board rate, or if the Hospital does not have semi-private accommodations, 80°/o of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

•During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO

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

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:	
•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment	
-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once Coinsured Charge Limit has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by:	
	a Network Provider	**an Out-Network Provider**
The Coinsurance for this Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
-a Hospital	None	20%
-An Ambulatory Surgical Center	None	20%
-A Birthing Center	None	20%
-an Extended Care Center or Rehabilitation Center	None	20%
-a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
-Prescription Drugs	None	20%
-Blood Transfusions	None	20%
-Infusion Therapy	None	20%
-Chemotherapy	None	20%

-Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

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

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

•During a Period of Hospital Confinement
For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi- private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

•During a Confinement In An Extended Care Center Or Rehabilitation Center
[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Coinsurance)	
-per Covered Person	$100
[-per Covered Family	$300]
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000.000

PREMIUM RATES
[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	**Premium Rate**
Health Benefits	
-per Employee	$9999.99]
[-per Employee and spouse	$9999.99
-per Employee and child(ren)	$9999.99
-per Employee, spouse and child(ren)	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY
The entire Policy consists of:
[a) the forms shown in the Policy Index as of the Effective Date;
b)] the Policyholder's application, a copy of which is attached to this Policy;
[c)] any riders, [endorsements] or amendments to this Policy and
[d)] the individual applications, if any, of the persons covered.

STATEMENTS
No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a) in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
b) in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY
There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

AMENDMENT
This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

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

No change in this 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)] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].
[c)] In the case of a change required by [Carrier], it is shown in an amendment to it that:
- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

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

AFFILIATED COMPANIES
If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS
The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees [and Dependents] then covered.

Premium payments may be determined in another way. But it must produce the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee [and/or Dependent] whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a) The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's [and/or Dependent's] coverage has ended.
b) The amount of any claims paid to an Employee for the Employee's claims [or to a member of the Employee's family unit] after that person's coverage has ended.]

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES
The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a) Any premium due date.
b) Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) Any date that the extent or nature of the risk under this Policy is changed:
- by amendment of this Policy; or
- by reason of any provision of law or any government program or regulation; or
- if this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.

d) At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. (If an eligible Employee is not covered by this Policy because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder.

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

CLERICAL ERROR - MISSTATEMENTS
Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE
[Carrier] has the right to non-renew this Policy on any premium due date subject to 60 days advance written notice to the Policyholder for the following reasons:
a. the Policyholder moves its principal place of business outside the state of New Jersey;
b. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
c. subject to the statutory notification requirements, [Carrier] ceases offering and non-renews a particular type of Health Benefits Plan in the small group market;
d. less than [75%] of the Employer's eligible Employees are covered by this Policy. If an eligible Employee is not covered by this Policy because:
1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements;
e. the Policyholder does not contribute at least 10% of the annual cost of the Policy; or
f. the Policyholder ceases membership in an association or multiple employer trust but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Covered Person.

[Carrier] has the right to non-renew this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reason:

During or at End of Grace Period- Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.

f) Immediate cancellation will occur if the Policyholder but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Covered Person

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on the Policy Anniversary following the date the Policyholder no longer meets the requirements of a Small Employer as defined in this Policy.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the action(s) described above as of the Employer's Policy Anniversary.

[DIVIDENDS
[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all 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 the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE
[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

a) to whom [Carrier] pays benefits,
b) any protection and rights when the coverage ends, and
c) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS
[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER
Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW

Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the, end of the time within which proof of loss is required.

WORKERS' COMPENSATION
The health benefits provided under this Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS - INFORMATION TO BE FURNISHED
[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct incorrect data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee [and Dependents] eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee[and Dependent] coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee[or Dependent] coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage should have ended.]

CLAIMS PROVISIONS
A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:
a) his or her estate;

b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS
[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS
A Covered Person cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

a) agrees to participate in the trust, and
b) applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed
The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

[**Actively at Work** or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;

c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out it's stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] 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.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

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

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the **Cash Deductible** section of this Policy for details.

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

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Charges.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read this entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or [a Dependent] who is insured under this Policy.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health 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.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means an Employee's:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time student status will be as defined by the accredited school.

A Dependent is not a person who is:
a) on active duty in any armed forces of any country; or
b) eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a) his or her legally adopted children,
b) his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:
a) designed and able to withstand repeated use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful to a Covered Person in the absence of an Illness or Injury; and
d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee [or Dependent], as the context in which the term is used suggests.

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

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period.

Experimental or Investigational means [Carrier] determines a service or supply is:

a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] 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.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a) Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopoeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b) Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c) demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d) Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e) Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is 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.

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

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

Group Health Plan means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. 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 means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.
Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person.

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

Injury means all damage to a Covered Person's body, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

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

Medical Emergency means 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. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

A near term delivery is not a Medical Emergency.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs;
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental or Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

[**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

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

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Planholder" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased this group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

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

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

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:
• the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will 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 means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in this Policy.

Skilled Nursing Care means 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 (see Extended Care Center.)

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

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Substance Abuse means abuse of or addiction to drugs.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

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

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

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

[**We, Us, Our** and **[Carrier]** mean [Carrier].]

[**You, Your and Yours** mean the Employer.]

EMPLOYEE COVERAGE

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

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

Conditions of Eligibility

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

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment.

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

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

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

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

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

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

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

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

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

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

Multiple Employment
If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Policy.

But, if this Policy uses the amount of an Employee's earnings to determine class, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

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

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

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

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

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Employee was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

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

When Employee Coverage Ends
An Employee's insurance under this Policy will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a]Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Policy.
c) the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d) the last day of the period for which required payments are made for the Employee, subject to the **Payment of Premiums - Grace Period** section.

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

[DEPENDENT COVERAGE

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

A Dependent is not a person who is:
a) active duty in any armed forces of any country; or
b) eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:
a) his or her legally adopted children,
b) his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and this Policy, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a) the child's condition started before he or she reached this Policy's age limit;
b) the child became insured by this Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and
c) the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

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

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

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

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

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

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

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

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

When Dependent Coverage Starts

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

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date the Employee signs the enrollment form; or
b) the date the Employee becomes insured for Employee coverage.

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

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

If the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

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

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

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

When Dependent Coverage Ends:
A Dependent's insurance under this Policy will end on the first of the following dates:

a) [the date] Employee coverage ends;
b) the date the Employee stops being a member of a class of Employees eligible for such coverage;
c) the date this Policy ends;
d) the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class;
e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons;
f) at 12:01 am on the date the Dependent stops being an eligible Dependent.

Read this Policy carefully if Dependent coverage ends for any reason Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.

b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d) ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

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

The Primary Care Practitioner (PCP)

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services
If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

In the case of a Medical Emergency, a Covered Person may go to a [XYZ 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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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.

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

Benefits
The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.
[**Note:** Used only if coverage is issued as POS.]

[APPEALS PROCEDURE

Carrier may elect to include an appeal 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 Departments of Health and Banking and Insurance, it may include that approved Grievance Procedure language in the standard SEH forms.

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

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

BENEFIT PROVISION

The Cash Deductible
Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.]

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

[Coinsurance Cap
This Policy limits Coinsurance amounts each Calendar Year except as stated below. The Coinsurance Cap cannot be met with:
a) Non-Covered Charges;
b) Cash Deductibles; and
c) Copayments.

There is Coinsurance Cap for each Covered Person.

The Coinsurance Cap is shown in the Schedule.

Once the Covered Person's Coinsurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her 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.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

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

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

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so. the time satisfied will be used to satisfy this Policy's eligibility waiting period if:
a) the Employee was employed by the Employer on the date the Employer's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

Extended Health Benefits

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

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

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Charges while Hospitalized
[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a) Hospital room and board
b) Routine Nursing Care
c) Prescription Drugs
d) Blood transfusions
e) Infusion Therapy
f) Chemotherapy
g) Radiation Therapy
h) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

Except as stated below, [Carrier] covers charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a Cesarean Section.

[Carrier] provides such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of care described above, the mother may elect to participate in a home care program provided by [Carrier].]
[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Copayment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Copayment per Calendar Year.

Testing Charges
[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges
Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

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

1. The Covered Person's 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 the Covered Person's 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.

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.

3. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
4. 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.
5. [Carrier] does not pay for:

- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment
[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

[Carrier] covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges
[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and

c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges
[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy
This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges
[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

Anesthetics
[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and [DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, , the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under this Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Policy, [Carrier] will provide credit as follows. [Standard method][[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under this Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] only covers 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 a Non-Covered Charge.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a) *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
b) *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.

[Carrier covers the therapy Services listed below but only when provided on an Inpatient basis.

c) *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
d) *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
e) *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
f) *Speech Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, combined, is limited to 30 visits per Calendar Year.

g) *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
h) *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

i) *Infusion Therapy* - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Fertility Services
Subject to [Carrier] Pre-Approval [Carrier] covers charges for inpatient procedures to enhance fertility.

Charges in connection with Fertility Services which are not Pre-Approved by [Carrier], or which are specifically excluded, are Non-Covered Charges.

Preventive Care
[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person[, $300 per Covered Family].

Immunizations and Lead Screening
[Carrier] 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.

[Transplant Benefits
[Carrier] covers charges 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.]

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:
a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission;
d) the name and location of the Hospital;
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.][Coinsured Charge Limit.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.
`When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery; or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC],]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%] if:**
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.][Coinsured Charge Limit.]

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

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under this 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 [DEF] or (Carrier] to be catastrophic.

Alternate Treatment Plan

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

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Carrier].

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d) estimated cost and savings.

If [Carrier], [DEF], 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 this 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.

Exclusion
Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

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

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

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

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

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

Services for ***ambulance*** for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***dose-intensive chemotherapy***[,except as otherwise stated in this Policy.]

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer, embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygotr Intra-fallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related ***to Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

Services or supplies related to ***Hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or ***Injury***, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental or Nervous Conditions and Substance Abuse.***

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

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

Non-prescription drugs or supplies, except
a) insulin needles and syringes an glucose test strips and lancets; and
b) colostomy bags, belts and irrigators

Services provided by a licensed ***pastoral counselor in*** the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care

Practitioner visits, except as otherwise stated in this Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible **Provider.**

Services related to ***Private-Duty Nursing care***, except as provided under the Home Health Care section of this Policy.

Prosthetic Devices

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker***, except as otherwise stated in this Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the Covered person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
- Subject to [Carrier] Pre-Approval, full-time student status, provided the Covered person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants [, except as otherwise stated in this Policy.].

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a) he or she was not terminated due to gross misconduct; and
b) he or she is not entitled to Medicare.

The continuation:
a) may cover the Employee and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:
a) his right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation, due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is not longer disabled under Title 11 or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this Policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End
If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would

otherwise end at this time. If an Employee acquires one or more Dependents after the continued health coverage begins, he or she may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends
A Covered Person's continued health coverage end on the first of the following:
a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the Covered Person becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e) with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying;

b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

A EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN
HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends
Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY
Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in] the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period, to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit
The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered for health benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS
"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) any group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance; nor
f) any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate 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 plan or any other plan. 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, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide 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 plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works
[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a) A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c) Except for Dependent children of separated or divorce parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information
In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver
[Carrier] does 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 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) this Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.
If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if this Policy had been primary.

Medicare
If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how this Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVI of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or

c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary
When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a Covered Person who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary plan. This Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis

of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"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 [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] 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 [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] 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.

[Carrier] 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 [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

[Carrier] 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.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare

Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c) If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT B

(RESERVED)

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan B]".

EXHIBIT E

(RESERVED)

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan E]".

EXHIBIT F

[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 1998]

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

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

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]
SEH B,C,D,E
["DC" THIS SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS INDEMNITY PLAN AND THE HMO PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

POLICY INDEX

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["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under the HMO Plan)	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the HMO Plan's Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under this Indemnity Plan)	
Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family] [Note: Must be individually satisfied by 2 separate [Members]] [$750, $1500, $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] **[except as stated below]**
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS Unlimited, **except** as otherwise stated]

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN B]**
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500, or $3000]

Hospital Confinement Copayment	
- per day	$200
- maximum Copayment per Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000

Emergency Room Copayment (waived if admitted within 24 hours)	$50

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows: 40%

Coinsurance Caps

Per Covered Person per each Calendar Year	$3,000
[Per Covered Family per each Calendar Year	[$6,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]] [$9000]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN C]**
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children for all other Covered Charges	NONE
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500, or $3000]

Emergency Room Copayment (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows: 30%

Coinsurance Caps

Per Covered Person per each Calendar Year	$2,500
[Per Covered Family per each Calendar Year	[$5,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]] **[$7500]**

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN D]**
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children for all other Covered Charges	NONE
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

[$750, $1500 or $3000]

Emergency Room Copayment (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows: 20%, **except as stated below**

Exception: for Mental or Nervous and Substance Abuse charges 25%

Coinsurance Caps
Per Covered Person per each Calendar Year $2,000
[Per Covered Family per each Calendar Year [$4,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]]
[$6000]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN E]**
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$150]
[Per Covered Family	[$300] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$450]

Emergency Room Copayment. (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows: 10%, **except as stated below**
Exception: for Mental or Nervous and Substance Abuse charges 25%

Coinsurance Caps
Per Covered Person per each Calendar Year $1,500
[Per Covered Family per each Calendar Year [$3,000. **Note:** Must be individually satisfied by 2 separate Covered Persons]]
[$4500]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles

- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (using Plan B, without Copayment)
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Hospital Confinement Copayment	
- per day	$200
- maximum Copayment par Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000
Emergency Room Copayment, (waived if admitted within 24 hours)	$50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. This Policy's Coinsurance , as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:	
• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

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

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (Using Plan C, with Copayment)
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:
CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment - If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible - If treatment services or supplies are given by an Out-Network Provider	
for Preventive Care	NONE
for immunizations and	

lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Emergency Room Copayment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by an Out-Network Provider	30%

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

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE INDEMNITY POS (Using Plan D)
This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS
Copayment- If treatment, services or supplies are given or referred by a PCP:

• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible - If treatment services or supplies are given by a Non-referred Provider

for Preventive Care for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Emergency Room Copayment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. This Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:

• if treatment, services or supplies are given or referred by the PCP	**None, except as stated below**
• if treatment, services or supplies are given by a	**20%, except as stated below**

non-referred Provider

Exception: for Mental or Nervous and Substance Abuse charges
• if treatment, services or supplies are given or referred by the PCP 0%
• if treatment, services or supplies are given by a non-referred Provider 25%

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

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) [PLAN B]
Daily Room and Board Limits

During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

During a Confinement In An Extended Care Center Or Rehabilitation Center
[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

[Plan B (Continued)]

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) 120 days

Charges for therapeutic manipulation per Calendar Year 30 visits

Charges for speech and cognitive therapy per Calendar Year (combined benefits) 30 visits

Charges for physical or occupational therapy per Calendar Year (combined benefits) 30 visits

Charges for Preventive Care per Calendar Year as follows:
(Not subject to Cash Deductible or Coinsurance)

[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment of Mental or Nervous Conditions and Substance Abuse, per Calendar Year	
Inpatient Confinement	30 days *
Outpatient Care	20 visits

* Unused Inpatient days may be exchanged, on a two-for-one-basis, for additional Outpatient visits.

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) [PLANS C, D E]
Daily Room and Board Limits

During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi private room and board rate.

For private room and board accommodations. [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:
a. the centers actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

[Plans C, D, E (Continued)]

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits

Charges for Preventive Care per Calendar Year as follows:

(Not subject to Cash Deductible or Coinsurance)

[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person

Charges for all treatment of Mental or Nervous Conditions and Substance Abuse, per Calendar Year	
Inpatient Confinement	30 days *
Outpatient Care	20 visits

* Unused Inpatient days may be exchanged, on a two-for-one-basis, for additional Outpatient visits.

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

["DC" THIS INDEMNITY PLAN AND THE ASSOCIATED HMO PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THIS INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THE HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THE HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THIS INDEMNITY PLAN.]

[FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THE HMO PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE COVERED PERSON RECEIVES UNDER THE HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THIS INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THIS INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE COVERED PERSON RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THE HMO PLAN AND THE COVERED CHARGES SECTION OF THIS INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

PREMIUM RATES

[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	Premium Rate
Health Benefits	
- per Employee	$9999.99]
[- per Employee and spouse	$9999.99
- per Employee and child(ren)	$9999.99
- per Employee, spouse and child(ren)	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

["DC" Note: The premium rates set forth above are for coverage under this Indemnity Plan only. Refer to the HMO Plan issued in conjunction with this Indemnity Plan for information on the premium rates applicable to the HMO Plan coverage.]

GENERAL PROVISIONS

THE POLICY
The entire Policy consists of:
[a. the forms shown in the Policy Index as of the Effective Date:
b.] the Policyholder's application, a copy of which is attached to this Policy;
[c.] any riders, [endorsements] or amendments to this Policy; ["DC" and]
[d.] the individual applications, if any, of the persons covered[.]["DC" and
e. the associated HMO Plan.]

STATEMENTS
No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:
a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY
There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

AMENDMENT
This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

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

No change in this 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.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].
[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:
• is signed by an officer of [Carrier]; and
• is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.
[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

AFFILIATED COMPANIES
If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS
The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees [and Dependents] then covered.

Premium payments may be determined in another way. But it must produce the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee [and or Dependent] whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:
a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's [and or Dependent's] coverage has ended.
b. The amount of any claims paid to an Employee for the Employee's claims [or to a member of the Employee's family unit] after that person's coverage has ended.]

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:
a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
• by amendment of this Policy; or
• by reason of any provision of law or any government program or regulation; or
• If this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. (If an eligible Employee is not covered by this Policy because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder.

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

CLERICAL ERROR - MISSTATEMENTS
Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], [or the amount of coverage], subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy, [and in what amounts].

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE
[Carrier] has the right to non-renew this Policy on any premium due date subject to 60 days advance written notice to the Policyholder for the following reasons:
a) the Policyholder moves its principal place of business outside the state of New Jersey;
b) subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
c) subject to the statutory notification requirements, [Carrier] ceases offering and non-renews a particular type of Health Benefits Plan in the small group market;
d). less than [75%] of the Employer's eligible Employees are covered by this Policy. If an eligible Employee is not covered by this Policy because:
1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,
[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements;
e) the Policyholder does not contribute at least 10% of the annual cost of the Policy; or
f) the Policyholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Covered Person
[Carrier] has the right to non-renew this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reason:

During or at End of Grace Period- Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.

Immediate cancellation will occur if the Policyholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Policy.

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on the Policy Anniversary following the date the Policyholder no longer meets the requirements of a Small Employer as defined in this Policy.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the action(s) described above as of the Employer's Policy Anniversary.

[DIVIDENDS
[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all 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 the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE
[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:
a. to whom [Carrier] pays benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET
[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS
[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER
Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW
Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION
The health benefits provided under this Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS - INFORMATION TO BE FURNISHED
[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct incorrect data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee [and Dependents] eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee [and Dependent] coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee [or Dependent] coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage should have ended.]

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS
[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS
A Covered Person cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS
The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder
An Employer must submit a signed application in which he:
a. agrees to participate in the trust; and
b. applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder
The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder
The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed
The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[Note: This text, which may be modified by each carrier in order to accommodate various trust agreements. It is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

[**Actively at Work** or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out it's stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] 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.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is 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.

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

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or

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

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

["DC" HMO Plan means the Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier] in conjunction with this Indemnity Plan.]

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize It if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person.
["DC" Indemnity Plan means the Small Employer Health Benefits Policy issued by [Carrier].]

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

Injury means all damage to a Covered Person's body and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

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

Medical Emergency means 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. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

A near-term delivery is not a Medical Emergency.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title **XVIII** of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

Mental or Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

[**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

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

[PLAN B]

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption of coverage,

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

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

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

["DC". Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices: and
b) provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

[PLANS C,D,E]

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

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

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

["DC". Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. ["DC" Only eligible Dependents who the Employee includes for coverage under the associated HMO Plan may be enrolled under this Indemnity Plan.][Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

If the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

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

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

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

When Dependent Coverage Ends
A Dependent's insurance under this Policy will end on the first of the following dates:
a) [the date] Employee coverage ends;
b) the date the Employee stops being a member of a class of Employees eligible for such coverage;
c) the date this Policy ends;
d) the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f) at 12:01 a. m. on the date the Dependent stops being an eligible Dependent.
["DC" g) the date the Dependent ceases to be covered under the associated HMO Plan.]

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

d) treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse
[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy
This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges
[Carrier] covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]
["DC" NOTE: ANY NEWBORN CHILD SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

Anesthetics and Other Services and Supplies
[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood
[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges
[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But It must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to [Carrier's] Pre-Approval. [Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:
a) any purchases without [Carrier's] advance written approval;
b) replacements or repairs; or
c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor
[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of this Policy.

Nutritional Counseling
Subject to [Carrier] Pre-Approval, [Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which are not Pre-Approved by [Carrier] are Non-Covered Charges.

X-Rays and Laboratory Tests
[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.
Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.
And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does 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.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment
[Carrier] covers:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the Covered Person is 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 does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)
[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices
[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

[Carrier] will cover charges for:
a) one baseline mammogram for a female Covered Person, ages 35 - 39
b) one mammogram, every 2 years, for a female Covered Person, ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female Covered Person ages 50 and older.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under this Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Policy, [Carrier] will provide credit as follows. [Standard method][[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under this Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care
[Carrier] **only** covers 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 a Non-Covered Charge.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
g. *Speech Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
i. *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy* - subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.**
["DC" NOTE: ANY THERAPY SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPY BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Fertility Services
Subject to [Carrier] Pre-Approval [Carrier] covers charges for procedures and prescription drugs to enhance fertility.

Charges in connection with Fertility Services which are not Pre-Approved by [Carrier], or which are specifically excluded, are Non-Covered Charges.

Preventive Care
[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to:
a) $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per Covered Person for all other Covered Persons.

These charges are not subject to the Cash Deductible or Coinsurance.
["DC" NOTE: ANY PREVENTIVE CARE SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE UNDER THE INDEMNITY PLAN.]

Immunizations and Lead Screening
[Carrier] will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Vision Screening
[Carrier] covers eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Mental or Nervous Conditions and Substance Abuse
[Carrier] limits what [Carrier] pays for the treatment of Mental or Nervous Conditions and Substance Abuse. [Carrier] includes a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits coverage for all treatment of Mental or Nervous Conditions and Substance Abuse per Calendar Year to:
a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.
One or more of any unused Inpatient days may be exchanged on a two-for-one-basis for additional Outpatient visits.

[Carrier] does not pay for Custodial Care, education, or training.
["DC" NOTE: ANY MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Transplant Benefits
[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich
- Subject to [Carrier] Pre-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 [Carrier] are Non-Covered Charges.]**

h) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 am. to 9 pm. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.
When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance. [[Carrier] reduces what it pays for covered Hospital charges, by 50%] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.][Coinsured Charge Limit]]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.][Coinsured Charge Limit]]

[ALTERNATE TREATMENT FEATURES

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

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under this 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 [DEF] or [Carrier] to be catastrophic.

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

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Carrier].

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; Covered Person; Covered Person's family, if any; and
d) estimated cost and savings.

If [Carrier], [DEF], 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 this 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.

Exclusion
Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

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

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

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

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

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances, except as otherwise stated in this Policy.

Care or treatment by means of ***dose intensive chemotherapy***, except as otherwise stated in this Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygotr Intra-fallopian Transfer (ZIFT); and b) drugs and therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related to ***Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

["DC" Services or supplies provided under the associated ***HMO Plan.***]

Services or supplies related to ***Hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or ***Injury***, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

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

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services***, except as otherwise stated in this Policy.

Supplies related to ***Methadone*** maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

Non-prescription drugs or supplies, except
a) insulin needles and syringes an glucose test strips and lancets; and
b) colostomy bags, belts and irrigators

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care***, except as provided under the Home Health Care section of this Policy.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care*** except:
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker***, except as otherwise stated in this Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the Covered person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
- Subject to [Carrier] Pre-Approval, full-time student status, provided the Covered person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in this Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war***, declared or undeclared: police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:
a) he or she was not terminated due to gross misconduct; and
b) he or she is not entitled to Medicare.

The continuation:
a) may cover the Employee and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and

b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is not longer disabled under Title 11 or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this Policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End
If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. If an Employee acquires one or more Dependents after the continued health coverage begins, he or she may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends
A Covered Person's continued health coverage end on the first of the following:
a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the Covered Person becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e) with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

A EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or

her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See exceptions below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN
HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy ["DC" ,where this Indemnity Plan is issued in conjunction with an HMO Plan. This Effect of Interaction with a Health Maintenance Organization Plan provision does **not** apply to Employees and their Dependents who are HMO members due to coverage under this Indemnity Plan and the associated HMO Plan.] If the Employer does ["DC" offer HMO membership under an HMO plan *other than* the associated HMO Plan], the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP
Date Group Health Benefits Insurance Ends
Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY
Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in]the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit
The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health benefits by more than one plan. ["DC" For the purpose of this Coordination of Benefits and Services Provision, coverage under this Indemnity Plan and the associated HMO Plan constitutes coverage under only one plan. There will not be any Coordination of Benefits and Services between the Indemnity Plan and the associated HMO Plan under this provision.] For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) any group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance; nor
f) any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate 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 plan or any other plan. 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, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide 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 plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works
[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a) A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c) Except for Dependent children of separated or divorce parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information
In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver
[Carrier] does 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 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) this Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.
If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if this Policy had been primary.

Medicare
If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how this Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary
When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a Covered Person who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary plan. This Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"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 [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] 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 [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] 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.

[Carrier] 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 [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

[Carrier] 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.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c) If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).

EXHIBIT G

[Carrier] HMO PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT

CONTRACT HOLDER: [ABC Company]

GROUP CONTRACT NUMBER [G-12345]

GOVERNING JURISDICTION NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [January 1, 1998]

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

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

AFFILIATED COMPANIES: [DEF Company]

[Carrier], in consideration of the application for this Contract and the payment of premiums as stated herein, agrees to arrange [or provide] services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its General Provisions.

[Secretary President]

["DC" THIS SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS HMO PLAN AND THE INDEMNITY PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

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

[Covered Employee and Spouse..... $

Covered Employee and Child(ren).....$

Covered Employee and Family.....$
(including Covered Employee, spouse and one or more eligible dependents)]

We have the right to change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled " General Provisions."

["DC" Note: The premium rates set forth above are for coverage under this HMO Plan only. Refer to the Indemnity Plan issued in conjunction with this HMO Plan, for information on the premium rates applicable to the Indemnity Plan coverage.]

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

CLASS
[All eligible employees]

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under this HMO Plan)	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under the Indemnity Plan)	
Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family][Note: Must be individually satisfied by 2 separate [Members]] [$750, $1500, $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] [**except as stated below]**
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS Unlimited, **except** as otherwise stated]

SCHEDULE OF SERVICES AND SUPPLIES

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS[/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours)
SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	$15 Copayment/visit

HOME HEALTH CARE	Unlimited days, if preapproved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if preapproved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	$25 Copayment for initial visit only; $0 Copayment thereafter.

MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT	$15 Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment: $1,500/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	$15 Copayment/visit; maximum 30 visits/Calendar Year
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CENTER	Unlimited days, if preapproved; $0 Copayment.
THERAPY SERVICES	$15 Copayment/visit.

DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	$15 Copayment/visit

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A[MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

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

["DC" THIS HMO PLAN AND THE ASSOCIATED INDEMNITY PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THE INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THIS HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THIS HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THE INDEMNITY PLAN.]

[FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THIS CONTRACT WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE [MEMBER] RECEIVES UNDER THIS HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THE INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THE INDEMNITY PLAN WHICH ARE SUBJECT TO

LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THIS HMO PLAN AND THE COVERED CHARGES SECTION OF THE INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies are provided.

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

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

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

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

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

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

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

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

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

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

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

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a [Member]. Coinsurance does not include Copayments.]

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

CONTRACTHOLDER. Employer or organization which purchased this Contract.

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

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

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

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract.

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

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

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

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

Even if a Covered Person is in a Hospital or other recognized Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT.
An Employee's:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of this Contract.

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

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

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

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a[Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a[Member]'s home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

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

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies which We Determine are:

a) not of proven benefit for the particular diagnosis or treatment of a[Member]'s particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a[Member]'s particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a[Member]'s particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a[Member]'s particular condition, as explained below.

We 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:

I. The American Medical Association Drug Evaluations;
II. The American Hospital Formulary Service Drug Information; or
III. The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

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

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

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

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

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network][Participating] Providers provide Covered Services and Supplies to[Members].]

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

[**"DC" HMO PLAN.** The Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier].]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

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

["DC" INDEMNITY PLAN. The Small Employer Health Benefits Policy issued by [Carrier] in conjunction with this HMO Plan.]

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

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

INPATIENT. [Member] if physically confined as a registered bed patient in a Hospital or other 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.

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

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

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We [or the Care Manager] Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a[Member]'s convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-Participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee[and covered Dependents, if any)].

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

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

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

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

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in this Contract.

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

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

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

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

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

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

["DC" POINT OF SERVICE PLAN. Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition. See the **Non-Covered Services and Supplies** section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:

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

c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

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

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

PROVIDER. A recognized Facility or practitioner of health care.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that directs a [Member] to a Facility or Provider for health care.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

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

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

SURGERY.

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

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

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

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

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

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

YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

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

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

Conditions of Eligibility

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

Enrollment Requirement

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

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

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

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

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

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

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

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

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

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

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

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

When Employee Coverage Starts

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

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

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

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

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

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

When Employee Coverage Ends
An Employee's coverage under this Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Contract.
c) the date this Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) [the date] for which required payments are not made for the Employee, subject to the **Payment of Premium - Grace Period** section.
e) [the date] an Employee moves his or her permanent residence outside the Service Area.]
["DC" f) [the date] an Employee ceases to be insured under the associated Indemnity Plan.]

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

[DEPENDENT COVERAGE

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

[Exception: Any dependent who does not reside in the Service Area is not an eligible Dependent.]

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

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

Incapacitated Children

An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the
terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached this Contract's age limit;
b) the child depends on the Employee for most of his or her support and maintenance; and
c) the child became covered by this Contract or any other policy or contract before the child reached the age limit and stayed continuously covered after reaching such limit.

But, for the child to stay eligible, the Employee must send Us written proof that the child is handicapped and depends on the Employee for most support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. ["DC" Only eligible Dependents who the Employee includes for coverage under the associated Indemnity Plan may be enrolled under this HMO Plan.] [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) make written request to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth.]

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

When Dependent Coverage Ends:
A Dependent's coverage under this Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date this Contract ends;
[d)]. the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Spouse, the date the Spouse moves his or her permanent residence outside the Service Area.]
["DC" h) the date the Dependent ceases to be insured under the associated Indemnity Plan.]

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

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

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

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

The extension ends on the earliest of:

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

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

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:
a) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the[Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any identification card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the coverage after that date.

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

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

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

["DC" Note: Under the terms of the associated Indemnity Plan, there is no requirement that the Member contact a Primary Care Physician to access services or supplies, but all benefits are subject to the terms and conditions of the associated Indemnity Plan.]

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

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

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

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

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

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [PARTICIPATING] SERVICES AND SUPPLIES
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Participating] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Participating] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Participating] Practitioner. If such [Participating] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Participating] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences ["DC" under this HMO Plan]. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding position of the [Participating] Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the [Member] asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate this Contract in accordance with the General Provisions. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the [Participating] Practitioner will cooperate with the [Member] in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT
A [Member] has the right under New Jersey law to refuse life sustaining treatment. A [Member] who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS
We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate [Participating] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

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

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services ["DC" under this HMO Plan] are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a[Member] from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

COVERED SERVICES & SUPPLIES

["DC" Under this HMO Plan,] [Members] are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable copayments [or Coinsurance] as stated in the applicable Schedule of Services and Supplies.

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

1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by a [Member]'s Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member]'s employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by a [Member]'s Primary Care Physician and approved in advance by Us.
7. **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in this Contract.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and of a natural part of a [Member]'s body, or be needed due to a functional birth defect in a Appropriate), repairs, wigs, or dental prosthetics or devices.
9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Physician and arranged through Us.
10. **Prescription Drugs and contraceptives which require a Practitioner's prescription,** and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

    [A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the [Member's] Participating Provider.

    A supply will be considered to be furnished at the time the Prescription Drug is received.]
11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and approved in advance by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

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

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval:

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and

b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

a) up to 48 hours of inpatient care in a Participating Hospital following a vaginal delivery; and

b) a minimum of 96 hours of inpatient care in a Participating Hospital following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that inpatient care is medically necessary; or

b) the mother must request the inpatient care.

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

2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the[Member] is participating in a National Cancer Institute sponsored clinical trial.]

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

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

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

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member]'s Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services(such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member]'s Primary Care Physician [or the Care Manager], for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** [Members]are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.
["DC" NOTE: ANY MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered ["DC" under this HMO Plan] without prior written referral by a [Member]'s Primary Care Physician in the event of a Medical Emergency as Determined by Us.

1. A [Member]'s Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
a. Our review determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-emergency basis; and
c. We and the [Member]'s Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event [Members] are hospitalized in a Non-Participating Facility, coverage will only be provided until [Members] are medically able to travel or to be transported to a Participating Facility. If [Members]elect to continue treatment with Non-Participating Providers, We shall have no responsibility for payment beyond the date [Members] are Determined to be medically able to be transported.
In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the reasonable and customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written referral to a Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or [Members] shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

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

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

2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy, and Respiration Therapy.
["DC" NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPY SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

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

1. **Skilled nursing services**, provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide**, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to the [Member] is skilled in nature.

3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a[Member]'s medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member]'s Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

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

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless[Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a[Member].

Care and/or treatment by a **Christian Science Practitioner**.

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in this Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the [Member] with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine**.

Services or supplies related to **Hypnotism**.

Services or supplies necessary because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

["DC"[Services or supplies for which benefits are paid under the associated **Indemnity Plan.**]

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

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

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[**Pre-Existing Condition Limitations**:
The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or-who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the

Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.]

Any service provided without prior written Referral by the [Member]'s **Primary Care Physician,** except as specified in this Contract.

In the event of a Medical Emergency, the amount of any charge which is greater than the amount We Determine to be the **reasonable and customary charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member]'s sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

APPEAL PROCEDURE

[Appeal Procedure: Variable by Carrier as approved by the State of New Jersey.]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one plan. ["DC" For the purpose of this Coordination of Benefits and Services Provision, coverage under this HMO Plan and the associated Indemnity Plan constitutes coverage under only one plan. There will not be any Coordination of Benefits and Services between the HMO Plan and the associated Indemnity Plan under this provision.] For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

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

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

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

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

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are provided as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:

a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the[Member] is insured or covered for services under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

AFFILIATED COMPANIES
If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

An Employee of the Contractholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Contract. That Employee's service with multiple Employers will be treated as service with that one.

The Contractholder must notify Us in writing when a company stops being an Affiliated Company. As of this date, this Contract will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Contractholder or another Affiliated Company as eligible Employees.

AMENDMENT
The Contract may be amended, at any time, without a [Member]'s consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

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

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.

d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT
No assignment or transfer by the Contractholder of any of the Contractholder's interest under this Contract or by a [Member] of any of his or her interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under this Contract will reduce a [Member]'s Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, [or the amount of coverage], subject to this Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Contract, [and in what amounts].

CONFORMITY WITH LAW
Any provision of this Contract which, on its Effective Date, is in conflict with the laws of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

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

CONTRACT INTERPRETATION
We shall administer Contract in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

In the event this Contract is amended, and such amendment affects the material contained in the evidence of coverage, a rider or revised evidence of coverage reflecting such amendment will be issued to the Contractholder for delivery to affected Employees.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

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

If to a [Member]: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

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 a Contractholder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to the Contractholder for attachment to this Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

CONTRACT INTERPRETATION
We shall administer Contract in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an eligible Employee is not covered by this Contract because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Contractholder,

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

PREMIUM AMOUNTS
The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect and the Employees and Dependents then covered.

Premium payments may be determined in another way. But it must produce the same amounts and be agreed to by the Contractholder and Us.

The following will apply if one or more Premiums paid include Premium charges for a [Member] whose coverage has ended before the due date of that Premium. We will not have to refund more than [the amount of (a) minus (b):
a) the amounts of the Premium charges for the [Member] that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contractholder that the [Member]'s coverage has ended.
b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.]

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) any date that the extent or nature of the risk under the Contract is changed:
    1) by amendment of the Contract; or
    2) by reason of any provision of law or any government program or regulation;
d) at the discovery of a clerical error or misstatement as described below.

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

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to Determine the premium rates and certify status as a Small Employer. All records of the Contractholder and of the Employer which bear on this Contract must be open to Us for Our inspection at any reasonable time.

We will not have to perform any duty that depends on such data before it is received in a form that satisfies Us. The Contractholder may correct incorrect data given to Us, if We have not been harmed by acting on it. A person's coverage under this Contract will not be made invalid by failure of the Contractholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Contractholder will furnish Us the Employee [and Dependents] eligibility requirements of this Contract that apply on the Effective Date. Subject to Our approval, those requirements will apply to the Employee [and Dependent] coverage under this Contract. The Contractholder will notify Us of any change in the eligibility requirements of this Contract, but no such change will apply to the Employee [or Dependent] coverage under this Contract unless approved in advance by Us.

The Contractholder will notify Us of any event, including a change in eligibility, that causes termination of a [Member's] coverage immediately, or in no event later than the last day of the month in which the event occurs. Our liability to arrange or provide benefits for a person ceases when the person's coverage ends under this Contract. [If the Contractholder fails to notify Us as provided above, We will be entitled to reimbursement from the Contractholder of any benefits paid to any person after the person's coverage should have ended.]

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a[Member], and We furnish a copy to the[Member] or to the[Member]'s beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE

We have the right to non-renew this Contract on any premium due date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves its principal place of business outside the State of New Jersey;

b) subject to the statutory notification requirements, We cease to do business in the small group market;

c) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the small group market;

d) less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:

1) the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or

2) the Employee is covered under an alternate Health Benefits Plan offered by the Contractholder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e) the Contractholder does not contribute at least 10% of the annual cost of the Contract;

f) the Contractholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member].

g) there is no eligible Employee who resides, lives, or works in Our approved Service Area, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member.]; or

h) the Small Employer no longer has any enrollee in connection with this Contract who lives, resides, or works in Our Service Area and We would deny enrollment with respect to such Contract, as permitted by law.

We have the right to non-renew this Contract on any premium due date subject to 30 days advance written notice to the Contractholder for the following reason:

During or at End of Grace Period- Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. But the Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested. The Contractholder is liable to pay premiums to Us for the time this Contract is in force.

Immediate cancellation will occur if the Contractholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Contract.

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of coverage hereunder will begin and end at 12:01 a.m. Eastern Standard Time at the Contractholder's place of business.

The Contractholder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on the Contract Anniversary following the date the Contractholder no longer meets the requirements of a Small Employer, as defined in this Contract.

The Employer must certify to Us the Employer's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Employer fails to do this, We retain the right to take the actions described above as of the Employer's Contract Anniversary.

THE CONTRACT

The entire Contract consists of:
[a the forms shown in the Table of Contents as of the Effective Date;
b)] the Contractholder's application, a copy of which is attached to the Contract;
[c)] any riders, [endorsements] or amendments to the Contract; ["DC" and]
[d)] the individual applications, if any, of all[Members][.]["DC" and
e) the associated Indemnity plan.]

WORKERS' COMPENSATION
The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS
As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)**: If a[Member] is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a [Member] elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:
a) he or she was not terminated due to gross misconduct; and
b) he or she is not entitled to Medicare.

The continuation:
a) may cover the Employee and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60

days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or

b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
   • the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   •the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Contract ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End
If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then covered Dependents whose coverage would otherwise end at this time. If an Employee acquires one or more Dependents after the continued health coverage begins, he or she may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What the Employer Must Do

At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed covered under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends
A [Member]'s continued health coverage ends on the first of the following:
a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the [Member];
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the [Member], the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or

d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:
a) days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS
If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if excessive coverage exists using Our standards for excessive coverage. or
c) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.
"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.
"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered person received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare. Benefits will be payable as specified in the COORDINATION OF BENEFITS AND SERVICES section of this Contract.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **COORDINATION OF BENEFITS AND SERVICES** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a [Member] who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is

eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.

b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.

c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT H
CARD/MAIL
SEH-OR-1A

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

Drugs provided on an Outpatient basis for the treatment of Mental or Nervous Conditions and Substance Abuse are covered under this Rider for Prescription Drug Insurance. Drugs provided on an Inpatient basis to treat Mental or Nervous Conditions and Substance Abuse, however, are not covered under this Rider for Prescription Drug Insurance or the Prescription Drugs Covered Charge of the Policy. Rather, drugs for such Inpatient treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Policy.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed. and registered pharmacy operated by [ABC] or. with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:
• for Generic Drugs $5.00
• for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:
• for Generic Drugs NONE
• for Brand Name Drugs $5.00

After -the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
• immunization agents
• biological sera
• blood or blood plasma.
c) Charges for a Prescription Drug which is:
• labeled "Caution - limited by Federal Law to Investigational use"; or
• experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
• a Hospital
• a rest home
• a sanitarium
• an Extended Care Facility
• a Substance Abuse Center
• an alcohol abuse or mental health center
• a convalescent home
• a nursing home
or similar institution.

h) Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental Fluorides.
l) Charges for any drug used in connection with baldness.
m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-1B
RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

Drugs provided on an Outpatient basis for the treatment of Mental or Nervous Conditions and Substance Abuse are covered under this Rider for Prescription Drug Insurance. Drugs provided on an Inpatient basis to treat Mental or Nervous Conditions and Substance Abuse, however, are not covered under this Rider for Prescription Drug Insurance or the Prescription Drugs Covered Charge of the Policy. Rather, drugs for such Inpatient treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Policy.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a) the greater of a 30 day supply or 100 unit doses; and
b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c) Charges for a Prescription Drug which is:
- labeled "Caution - limited by Federal Law to Investigational use"; or
- experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner.

e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.
h) Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.
i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental Fluorides.
l) Charges for any drug used in connection with baldness.
m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-1C
RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Mail Order Pharmacy for take-home use; and
c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c) Charges for a Prescription Drug which is:
- labeled "Caution - limited by Federal Law to Investigational use"; or
- experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home

- a nursing home

or similar institution.

h) Charges for:

- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i) Charges for vitamins, except Legend Drug vitamins.

j) Charges for drugs for the management of nicotine dependence.

k) Charges for topical dental Fluorides.

l) Charges for any drug used in connection with baldness.

m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT I
SEH-OR-2
RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:
Group Policy No:
Effective Date:

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and Substance Abuse and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only- covers drugs which are:

a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a) the Medical Necessity and Appropriateness;

b) the type of service involved;
c) the appropriate level of care required; and
d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co- Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:
a) days of Inpatient care per Calendar year; and
b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:
a) the Covered Person does not request a review in the times and manner described above;
b) the Covered Person's treatment does not comply with the treatment plan;
c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
d) [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.
[Carrier should insert Standard Rider Closure.]

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT J

CARD/MAIL (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

CARD (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

MAIL (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is supplemented with the following:

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Mail Order Pharmacy;
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:

a) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.

l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT K

(Plans A,B,C,D,E)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does not give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
b) Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO or POS)
h) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 16 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 17 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets (HMO Plan), set forth in Part 2 of Exhibit K, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and Co-Insurance Cap must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note**: ALL plans issued by a Carrier MUST include the same option.
4. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
5. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy - Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
8. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
9. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
10. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
11. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
12. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
13. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of

services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.

14. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Banking and Insurance for review and approval prior to use, as specified in regulation.
15. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
16. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
17. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:

    a. The policy and certificate documents contain "SAMPLE" schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:21-3(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier uses in conjunction with either the standard $15 copay plan or one of the optional plans, $5, $10, or $20.

    b. The Coinsured Charge Limit text that appears on the schedule must be included in lieu of the Coinsurance Cap text. The dollar amount of the Coinsured Charge limit is fixed at $10,000. There is no family Coinsured Charge Limit in the standard plan design.

    c. The Benefit Provision of the forms contains language for the Coinsurance Cap and for the Coinsured Charge Limit. Omit the Coinsurance Cap text and include the Coinsured Charge Limit text.

    d. Carriers may elect to include the appeals procedure that was approved by the State of New Jersey in connection with the filing of the Selective Contracting Arrangement.

    e. Include the specific page of text describing either the PPO or the POS mechanism, with specification of the name of the network or provider organization.

    f. If the plan includes utilization review provisions, the penalty provisions must include reference to the fact that the penalty does not count toward the satisfaction of the Coinsured Charge Limit.

17. Carriers that intend to use the standard indemnity forms as the non-network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Only Plans C and D may be used to provide the non-network benefits. Plans C and D must be issued as pure indemnity plans. That is, they may **not** be plans issued through or in conjunction with a Selective Contracting Arrangement.

Throughout the text, variable text which begins with "DC" appears. **All** of the variable text which is designated as "DC" text **must** be included when indemnity plans C or D are used as the non-network portion of a Dual Contract POS plan. **All** of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

While the Coinsured Charge Limit provision is generally used only when plans are issued through or in conjunction with an approved Selective Contracting Arrangement, indemnity plans that are issued as the non-network portion of a Dual Contract POS Plan must include the Coinsured Charge Limit text. That is, include the $10,000 Coinsured Charge Limit on the Schedule, include Coinsured Charge Limit text in the Benefit Provisions and if UR features are included, refer to the Coinsured Charge Limit in the penalty provisions.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

18. The face page text may be modified to be consistent with a carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
19. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group plan.

20. As described in 18 above, variable schedule amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
21. The Payment of Premiums-Grace Period section may be omitted, at the carrier's option.
22. The definition of "You, Your and Yours" may be omitted by carriers that elect to refer to the employee as Employee, rather that in use the personal "You". Throughout the text, the words "You," "Your" and "Yours" must be replaced with "Employee" terminology.

(RIDERS)

All text which is enclosed in brackets [] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

PART 2

EXPLANATION OF BRACKETS (HMO PLAN CONTRACT AND EVIDENCE OF COVERAGE)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does ***not*** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], and [ABC].
b) Some areas of variability are noted with brief explanations within the text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.
e) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
f) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.

Note: Explicit guidance for the issuance of a Dual Contract POS product is set forth in item 13 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets Policy Forms set forth in Part 1 of Exhibit K, for guidance on the variable text that appears in the indemnity form that would be issued in conjunction with the HMO form to produce the Dual Contract POS plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract and Evidence of Coverage forms.

1. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
2. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
3. The Generic Drug definition can be deleted if not needed.
4. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE:** ALL plans issued by a Carrier must make the optional benefit available in the same manner.
5. The bracketed dispensing limit text contained in the prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
6. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
7. OB/GYNs can be considered Primary Care Physicians.
8. Eligible class references can be removed.

9. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
10. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
11. Small Claims Waiver can be deleted.
12. Percentage participation requirement as noted in the Participation Requirements and in the Termination of the Policy Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
13. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
14. Carriers that intend to use the standard indemnity forms as the network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Throughout the text, variable text which begins with "DC" appears. *All* of the variable text which is designated as "DC" text *must* be included when the HMO plan is used as the network portion of a Dual Contract POS plan. *All* of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

In addition to the above items, Carriers must consider the following in connection with the evidence of coverage forms:

14. The face page text may be modified to be consistent with a carrier's methods of evidence of coverage personalization. The evidence of coverage level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the document. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
15. The term "evidence of coverage" may be replaced with a similar term sued to identify the document provided to employees covered under an employer's group plan.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT L
PART 1
PATIENT INSTRUCTIONS
FOR HCFA 1500

To request reimbursement for medical expenses; please complete the attached form blocks 1 through 13. To assist you, follow the instructions below. Please remember that all statements must be accurate.

Please bring this claim form with you at the time the medical services are rendered. The provider of service is responsible for completing blocks 14 through 33.

When requesting reimbursement, you should also attach copies of itemized bills and receipts for the medical services for which you are submitting a claim.

PATIENT INSTRUCTIONS

Block 1

Place an "X" in the appropriate block which identifies the type of insurance program that applies to the claim.

Block 1a

Enter the Social Security number or unique identification number assigned by the insurance carrier or the individual in whose name the insurance is carried.

Block 2

Enter the patient's last name, first name and middle initial.

Block 3

Enter the patient's date of birth in a MMDDYY format. Example: 01 12 94 for January 12, 1994. Place an "X" in the appropriate gender box.

Block 4

Enter the last name, first name and middle initial of the individual in whose name the insurance is carried.

Block 5

Enter the mailing address of the patient.

Block 6

Place an "X" in the appropriate box which identifies the relationship of the patient to the insured individual.

Block 7

Enter the mailing address of the individual who holds the insurance if it is different from the patient's address listed in Block 5. Otherwise, enter the word "SAME".

Block 8

Place an "X" in the appropriate box which identifies the patient's marital status. Also, place an "X" in the appropriate box which identifies the employment/student status of the patient.

Block 9

If the patient has other insurance, enter the last name, first name and middle initial of the covered individual if it is different from that shown in Block 4. Otherwise, enter the word SAME.

Block 9a

Enter the other insurance carrier's identification number or unique code assigned by the carrier to identify the group or policy under which the individual in Block 9 is covered.

Block 9b

Enter the date of birth or the individual (listed in Block 9) in a MMDDYY format. Example: 011294 for January 12, 1994.

Enter an "X" in the appropriate gender box.

Block 9c

Enter the name of the individual's (listed in Block 9) employer or school name.

Block 9d

Enter the name of the insurance program covering the individual in Block 9.

Block 10a through 10c

Place an "X" in the appropriate box to indicate whether the patient's condition is related to employment, auto accident, or other accident. For auto accidents, indicate the states' abbreviation in which the accident occurred (e.g. New Jersey—NJ).

Block 10d

This field is not required.

Block 11

Enter the identification or unique code assigned by the carrier to identify the group or policy under which the individual is covered.

Block 11a

Enter the individual's (listed in Block 4) birthdate in a MMDDYY format. Example: 011294 represents January 12, 1994.

Place an "X" in the appropriate gender box.

Block 11b

Enter the individual's (listed in Block 4) **employer name or school name.**

Block 11c

Enter the name of the insurance program covering the individual in Block 4.

Block 11d

Place an "X" in the appropriate box. If the answer is YES, complete sections 9a-9d.

Block 12

The patient's signature in this field authorizes release of medical information necessary to process this claim. The patient or an authorized representative should sign and date this block unless the signature is on file in the provider's office/facility.

Block 13

The signature in this block authorizes the insurance carrier to release insurance benefits directly to the provider of the services listed in Block 33.

Repeal and New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT M

Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

GE 0094
Annual Family Profile
and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

Employer name	Employer phone number	Plan/Policy Number

Check one ☐ Active employee ☐ Retired employee ☐ Continued individual

Employee information

Name	Date of birth	Social Security Number

Address	City	State	ZIP	Home phone number

Do you have another employer? ☐Yes ☐No	If "Yes," please give name of other employer	Other employer's phone number

Are you covered by another group plan? ☐Yes ☐No	If "Yes," please give name of carrier	Plan number	Other carrier's phone number

Spouse Information

Name	Date of birth	Social Security Number

Name and address of spouse's employer	Phone number of spouse's employer

Is spouse covered by another group plan? ☐Yes ☐No	If "Yes," please give name of other carrier	Plan number	Other carrier's phone number

Dependent children information

Name	Date of birth ☐Male ☐Female	Social Security No.	Relation to employee	Handicapped ☐Yes ☐No

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

Name	Name of school	Address of school

If any child is covered by another group plan, please give the information requested below.

Name	Insured person	Name of carrier	Plan number

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

Signature of employee	Signature of patient if other than minor child	Date

SEH-FP-7/93

EXHIBIT N

[EXHIBIT N] *(1-98)*

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type Policy number ([Carrier] Use Only)

New Policy Change in Policy Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____
2. Tax Identification Number: _____
3. Main Address: _____
   Street City State Zip
   Mailing Address: _____
   Street City State Zip
   Telephone: ( )_____ Facsimile: ( )_____
4. Name of Correspondent: _____
5. Type of organization: Corporation Partnership
   Proprietorship Other (explain): _____
6. Nature of business (specify): _____
   SIC Code _____
7. Number of eligible employees in your company: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: Employees Only Employees & Dependents
11. Are you subject to the requirements of COBRA? Yes No
12. Waiting period before employees become insured: (may not exceed 6 months)
13. Present employees:_____ New or Rehired Employees:_____
14. What percentage of the premium will the employer pay?_____
15. Deposit $_____

Premium Paid: Monthly Quarterly [Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible employees in this company	No eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS

Wraparound (Hospital Base Plan ____ days)

Plan: A B C D E HMO HMO-POS Dual Contract POS

Deductible (Options for plans B, C and D only): $250 $500 $1,000

High Deductible Options: $ $

Co-Payment (Options for HMO Plans Only): $5 $10 $15 $20

Managed Care Delivery System: PPO POS None

PRESCRIPTION DRUG BENEFITS
Program Type: Card Mail Order Card/Mail Order

MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS
Co-Payment Option: $5 $10 $15 $20

NON-STANDARD OPTIONAL BENEFIT RIDERS

]

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? Yes No
   - currently being applied for? Yes No

   If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

2. Name of present or prior group carrier_____
   Effective date of prior coverage:_____
   Cancellation/termination date:_____

Is the coverage applied for in this application replacing other group insurance?
Yes No
If "Yes" give reason_____
Plan being replaced: A B C D E HMO HMO-POS Dual Contract
POS Other: _____

3. Has your firm been uninsured for 3 or more months prior to application?
   Yes No

4. What forms of insurance are now or were in force?
   Health Benefits Prescription Drugs (attach copies of Booklet / Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits?
   Yes No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?
   Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability /Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:

   a) Are any employees or dependents presently incapacitated?
      Yes No
   b) Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

_____

_____

SECTION IV: AGENT/PRODUCER INFORMATION

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

SECTION V: SIGNATURE

[It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

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

Date at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

EXPLANATION OF BRACKETS AND TEXT
APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

1. Contractholder or Planholder and Contract or Plan, as appropriate.

2. The terms Policyholder and Policy may be replaced with terms insurance and insured may be replaced with coverage and covered, as appropriate.

3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.

4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.

5. 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.

6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.

7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT O

[EXHIBIT O] *(1-98)*

NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a Group Health Benefits Plan

Employer Name _____ Group Policy No. _____

Address _____ Street _____ City _____ State _____ Zip _____

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a) employees, owners partners officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.
b) employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)	[Gender]	[Date of Birth]
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

If additional space is needed, attach a separate sheet.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay . An employee who works less than 25 hours per week, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # eligible Employees _____

Total # Eligible Employees applying / enrolling for health benefits coverage _____
Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____
Total # Eligible Employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____
Total # Employees in an ineligibile class or classes _____
[Is your firm subject to Working Aged Provisions (TEFRA / DEFRA)? Yes No]

[Is your firm subject to the requirements of COBRA? Yes No]

CERTIFICATION

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

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

I certify that the information provided to (Carrier) is true and complete, I understand that if the above information is not complete or is not provided to (Carrier) in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

_____
Signature of Officer, Partner or Owner Title Date

_____
_____
Print Name of Officer, Partner or Owner

_____
Signature of Witness Date

_____

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

_____
Signature of Officer, Partner or Owner Title Date

_____
Print Name of Officer, Partner or Owner

_____
Signature of Witness Date

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT P

(RESERVED)

EXHIBIT Q

[EXHIBIT Q] *(1-98)*

[Carrier]
SMALL GROUP EMPLOYER BENEFITS ENROLLMENT [AND CHANGE FORM] [AND PRE-EXISTING CONDITIONS STATEMENT]
Please print all information, using ink.
[Policyholder] (full legal name of company): _____ (Policy) No: _____
[Policyholder] Address: _____
Street City State Zip Code

SECTION I: EMPLOYEE INFORMATION

Name: _____
Last First Middle Initial
Home Address: _____
Street [Apt.] City [County] State Zip Code
[Telephone: _____ _____
Home Work
Best place to call during day: _____ Home _____ Work]
Occupation: _____ Title: _____
Date of Employment: _____ Hours worked per week: _____
Are you actively at work? _____ Yes _____ No If "No", explain: _____
Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced
[Are you a resident of the state of New Jersey? _____ Yes _____ No
Do you maintain a residency in another state? _____ Yes _____ No
If "Yes", name the state _____
How much time do you spend there each year? _____]

[REASON FOR COMPLETION OF THIS FORM (please check all appropriate responses)
____ I am an employee of an organization which is applying for coverage
____ I am now eligible for coverage
____ I had no previous coverage during the past 90 days
____ I had previous coverage during the past 90 days.
Name of previous carrier _____ Plan Number: _____
Effective Date: _____ Termination Date: _____
____ I previously refused/waived coverage
____ I am enrolling for coverage during my employer's open enrollment period.
Open Enrollment Date: _____
____ I am continuing under _____ Federal Law (COBRA) or _____ State Law
Qualifying Event: _____ Date Continuation began: _____
Continuation applies to: _____ Employee Only _____ Employee and Eligible Dependents
____ I am continuing under a total disability extension (Attach proof of disability)
____ I am terminating coverage for myself, and all dependents
____ I am adding/deleting dependents
____ Other (Specify): _____]

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within [30] days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within [30] days after the marriage, birth, adoption, or placement for adoption.

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: _____ Employee Only _____ Employee & Child(ren)
_____ Employee & Spouse _____ Employee, Spouse & Child(ren)
2. Please provide all information for each person to be covered [or deleted].

Full Name (Last, First, Middle Initial)	Add[/Delete]	Sex	Social Security No.	Birthdate
Employee				
Spouse				
Child				
Child				
Child				
Child				

Attach a separate sheet to list additional children. [Attach proof if full-time student. Attach proof of disability.]

[3. Do any of the dependents listed above live at an address other than the Home address given above?
_____ Yes _____ No If "Yes", name the dependent(s) and provide the address(es)

Explain the circumstances

4. If any dependent's last name differs from yours, explain the circumstances

[5. Are any of the dependents listed above confined in a facility or at home, due to a medical reason?
_____ Yes _____ No If "Yes", name the dependent(s), and the place and reason for confinement.

[6] Indicate whether any person to be covered is enrolled under Medicare, Parts A and/or B.

	Part A	Part B	Medicare ID #
Employee	___Yes___No	___Yes___No	_____
Spouse	___Yes___No	___Yes___No	_____
Child (give name)_____	___Yes___No	___Yes___No	_____

[7] Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?
_____ Auto _____ Medical

[[8] Are you, or any person to be covered, eligible for other health coverage? (i.e., employer sponsored group coverage, Medicare, Medicaid)
_____ Yes _____ No If "Yes", indicate the name(s) of the person(s), the name(s) of the carrier(s), the policy number(s) and the type(s) of coverage.

[9.] Have you, or any dependent(s), as a [Carrier] health plan member, received care at any [Carrier] health care center? _____ Yes _____ No
If "Yes", please indicate the medical record number in the space below. If the name of you or your dependent(s) was different at the time of receiving care, please indicate. (ex. maiden name)
[10] Are you replacing existing coverage? _____ Yes _____ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the names(s) of the persons covered by the policy.

[11.] Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan?
_____ Yes _____ No
If "Yes", attach the Certificate of Group Health Plan Coverage
Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the pre-existing conditions limitation, if applicable.

[SECTION III: CHANGE INFORMATION

[Type of Activity
____ Termination of Employee and Dependent Coverage [Please check reason(s) below]
Date of Termination _____
____ Add/Remove Dependent
Reason _____
Date of Event _____
____ New Telephone Number: (H) _____ (W) _____
____ Change Contract Type from _____ to _____
____ Change Name from _____ to _____
____ Change of PCP, GYN, Health Center (Circle which, state for whom and give new name) _____
____ Withdrawal from Coverage
Date of Event _____
____ New Address: _____
Street [Apt.] City [County] State Zip Code]

[Termination Check Reason(s)
____ Deceased ____ Transferred to Other Coverage ____ Dissatisfied with Coverage
____ Ineligible ____ Moved Out of Area ____ Dissatisfied with Medical Care
____ Dissatisfied with Access
Other, please explain: _____
Remarks: _____]]

[SECTION IV: 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 180 days. This*

limitation of benefits, services and supplies applies only to employer groups with 2 - 5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

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

		YES	NO
1. a.	Alcoholism or 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	____	____

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 of 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 & Address of Hospitals, Practitioners

[SECTION V: HEALTH CARE SELECTION

Full Name (Last, First, Middle Initial)	[Primary Care Physician]	[Health Care Center]	[GYN]
Employee			
Spouse			
Child			
Child			
Child			
Child			

[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.]

[Plan Selection: _____]

SECTION VI: DECLARATION [AND] AUTHORIZATION [AND CONDITIONS OF ACCEPTANCE]

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a) the coverage applied for will not take effect unless:
   - after review of this Enrollment Form, [Carrier] accepts it;
   - the first premium has been paid to [Carrier]; and
   - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under for a waiver of the active work requirement.

b) no person, except an officer of [Carrier] has authority to: determine whether [certificate/evidence of coverage] shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of the [Carrier's] requirements; to bind [Carrier] by any statement or promise pertaining to any [certificate/evidence of coverage] to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to [Carrier].

- [d [Carrier] does not pay benefits for charges, or provide services or supplies related to a pre-existing condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the pre-existing conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

[[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 state that I am a resident of New Jersey [and I live, reside or work within [Carrier's] service area.]][I understand that if I omit or falsify any statement on this enrollment form, [Carrier] can cancel my coverage as of the original effective date.]

Any person who includes any false or misleading information on an application or enrollment form [and change form] for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, [Carrier] will assist the person in obtaining a certificate from the prior plan or issuer.

[Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of [covered persons] [members] [subscribers] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to [receiving in-network] benefits, employee understands and agrees that (with the exception of emergency procedures as defined in the Contract) all [in-network] services, in order to be covered by [Carrier], must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. [Out-of-network benefits are covered, as stated in the contract.]
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employee understands that this coverage will remain in effect regardless of the continued availability of a particular [primary care physician] [health care center][other health care provider].
7. Employee acknowledges that [carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Authorization

1. I authorize the sources stated below to give to [Carrier], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorizes sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

Date signed	Signature of Employee
[	

Date signed

Signature of Spouse, if providing information on the pre-existing conditions statement

Date signed

Signature of Child who is 18 or older, if providing information on the pre-existing conditions statement]

Repeal and New Rule, R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Explanation of Brackets Small Employer Health Benefits".

Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT R

(RESERVED)

Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Enrollment Application and Change Form".

EXHIBIT S

(RESERVED)

Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Exhibit was "Health Maintenance Organization (HMO) Enrollment Application (and Change Form) Small Employer Health Benefits Plan for Employees and Dependants".

STATEMENT OF ERISA RIGHTS .....

CLAIMS PROCEDURE .....

PLAN A

SCHEDULE OF INSURANCE

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:

•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment

-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
- a Hospital	20%
- an Ambulatory Surgical Center	20%
- a Birthing Center	20%
- an Extended Care Center or Rehabilitation Center	20%
- a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
- Prescription Drugs	20%
- Blood Transfusions	20%
- Infusion Therapy	20%
- Chemotherapy	20%
- Radiation Therapy	20%
• for all other Covered Charges	50%
Coinsurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semiprivate room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semiprivate room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is

being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units. [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**
[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

SCHEDULE OF INSURANCE **EXAMPLE: PLAN A PPO**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:	
•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment	
-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However. [Carrier] will waive the Coinsurance requirement once the Co-Insured Charge Limit has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions. or any other Non-Covered Charge.

	If treatment, services or supplies are given by: a Network Provider	an Out-Network Provider
The Coinsurance for the Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
- a Hospital	None	20%
- an Ambulatory Surgical Center	None	20%
- a Birthing Center	None	20%
- an extended Care Center or Rehabilitation Center	None	20%
- a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
- Prescription Drugs	None	20%
- Blood Transfusions	None	20%
- Infusion Therapy	None	20%
- Chemotherapy	None	20%
- Radiation Therapy	None	20%

• for all other Covered Charges	70%	50%

The Coinsured Charge Limit means the amount of Covered Charges a Covered Person must incur each calendar year before no Coinsurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

• **During a Period of Hospital Confinement**
For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semiprivate room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semiprivate room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**
[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Coinsurance)	
-per Covered Person	$100
[-per Covered Family	$300]
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000.000

GENERAL PROVISIONS

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 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is

liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS
If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], [or the amount of coverage,] subject to the Policy's Incontestability section, the true facts will be used in determining whether coverage is in force under the terms of the Policy, [and in what amounts.]

[DIVIDENDS
[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET
[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS
[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW
Any provision of the Policy which, on its Effective Date, is in conflict with the laws of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION
The health benefits provided under the Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

CLAIMS PROVISIONS
A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:
a) his or her estate;

b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout the [certificate], these defined terms appear with their initial letter capitalized.]

[**Actively at Work or Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting ill or injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out it's stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate postpartum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] 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.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

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

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the **Cash Deductible** section of this [certificate] for details.

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

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Charges.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [carrier] limits or excludes.

Covered Person means an eligible Employee [or a Dependent] who is insured under the Policy.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health 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.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care. **Custodial Care** means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means Your:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time student status will be as defined by the accredited school.

A Dependent is not a person who is:
a) on active duty in any armed forces of any country; or
b) eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the Dependent Coverage section of this [certificate].

An Employee's "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children if such step children depend on You for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:
a) designed and able to withstand repeated use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful to a Covered Person in the absence of an Illness or Injury; and
d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.
Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee [or Dependent].

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

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period.

Experimental or Investigational means [Carrier] determines a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] 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.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a) Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b) Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c) Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d) Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e) Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is 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 the Policy.

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

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

Group Health Plan means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. 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 means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by the Joint Commission or
b) approved as a Hospital by Medicare.
c)
Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person.

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

Injury means all damage to a Covered Person's body, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility, or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

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

Medical Emergency means 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. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

A near term delivery is not a Medical Emergency.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs;
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental or Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders,

personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

[**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy", as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Outpatient means a Covered Person who is not confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient, or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"]

Planholder means Your Employer who purchased this group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"]

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

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

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or **Pre-Approved** means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition Limitation means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was

recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

Provider means a recognized Facility or Practitioner of health care in accordance with the, terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:
- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the 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 means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its' stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the Schedule of Insurance contained in the Policy and in this [certificate].

Skilled Nursing Care means 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 (see Extended Care Center.)

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

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

Substance Abuse means abuse of or addiction to drugs.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

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

Total Disability or **Totally Disabled** means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

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

[**We, Us, Our** and [**Carrier**] mean [Carrier].]

[**You, Your** and **Yours** mean an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

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

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility**.

Conditions of Eligibility

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

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

When an Employee initially waives coverage under this Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Policy and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation;
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.
But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under the Policy because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Policy within 30 days of the date the

COBRA continuation ended, [Carrier] will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

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

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

[The Waiting Period
The Policy has the following waiting periods:

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

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

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

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status Related Factor, and except as stated below,]You must be[Actively at Work, and] working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. [If You are not Actively at Work on the scheduled Effective Date and do not qualify for the Exception to the Actively at Work requirement, [Carrier] will postpone the start of Your coverage until You return to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.]

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

If You do this more than [30] days after Your Eligibility Date, [Carrier] will consider You a Late Enrollee. Coverage is scheduled to start on the date You sign the enrollment form.

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

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

When Employee Coverage Ends
Your insurance under the Policy will end on the first of the following dates:

a) [the date] You cease to be [an Actively at Work] [an] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] You stop being an eligible Employee under the Policy.
c) the date the Policy ends, or is discontinued for a class of Employees to which You belong.
d) the last day of the period for which required payments are made for You, subject to the **Payment of Premiums - Grace Period** section..

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are Your:
a) legal spouse;
b) unmarried Dependent children who are under age 19; and
c) unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:
a) on active duty in any armed forces of any country; or
b) eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the Incapacitated Children section of this [certificate].

Your "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children if such step children depend on You for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a) the child's condition started before he or she reached the Policy's age limit;
b) the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and
c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

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

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

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

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a) You are under legal obligation to provide coverage due to a court order; and
b) You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

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

In addition, if You initially waived coverage under the Policy for Your spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and You request coverage for the spouse and/or Dependent children under the Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date You sign the enrollment form; or
b) the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

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

If the Policyholder who purchased the replacement Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who Totally Disabled on the date the replacement Policy takes effect will initially be eligible for limited coverage under the replacement Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the replacement Policy takes effect immediately upon termination of the prior plan.

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

Newborn Children
[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:
a) If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, [provided the premium required for Dependent child coverage continues to be paid.] [and the Employee must notify [Carrier] of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If You are not covered for Dependent child coverage on the date the child is born, You must:
- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

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

When Dependent coverage Ends:
A Dependent's insurance under the Policy will end on the first of the following dates:

a) [the date] Your coverage ends;

b) the date You stop being a member of a class of Employees eligible for such coverage;
c) the date the Policy ends;
d) the date Dependent coverage is terminated from the Policy for all Employees or for Your class.
e) the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.
f) at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]
The 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 [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note**: Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

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

Provider Organization (PO)

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

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services
If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

In the case of a Medical Emergency, a Covered Person may go to a [XYZ 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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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.

Utilization Review
The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits
The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note**: Used only if coverage is issued as POS.]

APPEALS PROCEDURE

Carrier may elect to include an appeal procedure when the plan is issued including Preferred Provider Organization or Point of Service provisions. If a carrier has had a Selective Contracting Arrangement approved by the New Jersey Departments of Banking and Insurance and Health, it may include that approved Appeal Procedure in the standard SEH forms.

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible
Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.]

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

[Coinsurance Cap
The Policy limits Coinsurance amounts each Calendar Year except as stated below. The Coinsurance Cap cannot be met with:
a) Non-Covered Charges;
b) Cash Deductibles; and
c) Copayments.

There is Coinsurance Cap for each Covered Person.

The Coinsurance Cap is shown in the Schedule.

Once the Covered Person's Coinsurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her 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.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person's being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan
The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other carrier.

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

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy the Policy's eligibility waiting period if:
a) the Employee was employed by the Employer on the date the Employer's old plan ended: and

b) the Policy takes effect immediately upon termination of the prior plan.

Extended Health Benefits
If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

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

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Charges while Hospitalized
[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a) Hospital room and board
b) Routine Nursing Care
c) Prescription Drugs
d) Blood transfusions
e) Infusion Therapy
f) Chemotherapy
g) Radiation Therapy
h) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule

Except as stated below, [Carrier] covers charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an exception to the Medically Necessary and Appropriate requirement of the Policy, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of in-patient care described above, the mother may elect to participate in a home care program provided by [Carrier.]]
[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the Extended Care or Rehabilitation Charges, Home Health Care Charges and Hospice Charges sections.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Copayment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Copayment per Calendar Year.

Testing Charges
[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges
Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:
Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the 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. The Covered Person's 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 the Covered Person's 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.

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.
3. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
4. 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.
5. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment
[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

[Carrier] covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges
[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges
[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy
The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges
[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

Anesthetics
[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method][[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care
[Carrier] **only** covers 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 a Non-Covered Charge.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a) *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
b) *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.

[Carrier covers the therapy Services listed below but **only** when provided on an Inpatient basis.

c) *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
d) *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
e) *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
f) *Speech Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined**, is limited to 30 visits per Calendar Year.

g) *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
h) *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per Calendar Year.

i) *Infusion Therapy* - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

[Transplant Benefits
[Carrier] covers charges 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.]

Preventive Care
[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, [$300 per Covered Family.]

Immunizations and Lead Screening
[Carrier] 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.

Fertility Services
Subject to [Carrier] Pre-Approval, [Carrier] covers charges for in-patient procedures to enhance fertility.

Charges in connection with Fertility Services which are not Pre-Approved by [Carrier], or which are specifically excluded are Non-Covered Charges.

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the Centers of Excellence Features section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate] You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the, [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital Stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.] [Coinsured Charge Limit.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.
[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC],]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%**] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.] [Coinsured Charge Limit.]

[ALTERNATE TREATMENT FEATURES

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

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
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 [DEF] or [Carrier] to be catastrophic.

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

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Carrier].

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d) estimated cost and savings.

If [Carrier], [DEF], 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.

Exclusion
Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] 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 Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

Services for ***ambulance*** for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in the Policy; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***Dose Intensive Chemotherapy*** [except as otherwise stated in the Policy].

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer, embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygotr Intra-fallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related to ***Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

Services or supplies related to ***Hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental or Nervous Conditions and Substance Abuse.***

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

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of the Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.

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

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care

Practitioner visits, except as otherwise stated in the Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible **Provider**.

Services related to ***Private-Duty Nursing care***, except as provided under the Home Health Care section of this [certificate].

Prosthetic Devices

The amount of any charge which is greater than a ***Reasonable and Customary Charge***.

Services or supplies related to ***rest or convalescent cures***.

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care***.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker***, except as otherwise stated in the Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and / or treatment, and the travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
- Subject to [Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which

the student matriculates in the United States, grants academic credit. **Charges in connection with full-time student status in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation

Transplants [except as otherwise stated in the Policy].

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:
a) Your Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under the Policy during a continuation provided by this section is not qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:
a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:
a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours or during the first 60 days of continuation coverage, You and any qualified continuee who is not disabled may elect to extend the 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Your Dependents who become entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon Your subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of Your termination of employment or reduction in work hours; or
b) 36 months from the date of Your earlier entitlement to Medicare.

Exception: If You become entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue the Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.
Such written notice must be given to the qualified continuee within 14 days of:

a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hour; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is not longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date the Policy ends;
f) the end of the period for which the last premium payment is made;

g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End
If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. If You acquire one or more Dependents after the continued health coverage begins, You may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify You, in writing, of:
a) Your right to continue the Policy's group health benefits;
b) the monthly premium You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends
a) A Covered Person's continued health coverage end on the first of the following:
b) the date which is 12 months from the date the small group benefits would otherwise end;
c) the date the Covered Person becomes eligible for Medicare;
d) the end of the period for which the last premium payment is made;
e) the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
f) with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
g) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
h) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How An When To Continue Coverage
To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if You stop paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Policy ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

A EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:
a) Your Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to You.

If An Employee's Group Health Coverage Ends
Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date You return to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a) 180 days following the date of Your death; or
b) the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends
Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends
When You become an HMO member, the Extended Health Benefits section of this [certificate] will not apply to You and Your Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 90 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in] the HMO service area

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, You and Your her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent
If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your her Dependents will be Late Enrollees.

request made at any other time
You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period, to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit
The total amount of benefits to be paid for each person will be the `maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) any group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance; nor
f) any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate 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 plan or any other plan. 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, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification

of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide 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 plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works
[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a) A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information
In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give (Carrier] all the information (Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver
[Carrier] does 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 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) the Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.
If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.
If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if the Policy had been primary.

Medicare
If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such, rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an' Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare a$ his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary
When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a Covered Person who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits** section of the Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits** section of the Policy.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.
"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 [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] 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 third party settlement;
a satisfied judgment; or
a) other means.

[Carrier] 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 [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not provide benefits under the 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.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c) If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.
d) [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT W

[Carrier] **PLANS B, C, D, E**
SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE;	01-01-98
CALENDAR YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$250
PER COVERED FAMILY:	$500
COINSURANCE:	20%
COINSURANCE CAPS	
PER COVERED PERSON:	$2,000
PER COVERED FAMILY:	$4,000]

[Secretary President]

[Dividends are apportioned each year.]

["DC" THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS INDEMNITY PLAN AND THE HMO PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

CERTIFICATE INDEX

SECTION	PAGE(S)
["DC" Overview of Point of Service Plan]	
Schedule of Insurance	
General Provisions	
Claim Provisions	
Definitions	
Employee Coverage	
[Dependent Coverage]	
[Preferred Provider Organization Provisions]	
[Point of Service Provisions]	
[Grievance Procedure]	
Health Benefits Insurance	
[Utilization Review Features]	
[Alternate Treatment Features]	
[Centers of Excellence Features]	
Exclusions	
Continuation Rights	
[Conversion Rights for Divorced Spouses]	
[Effect Of Interaction with a Health Maintenance Organization Plan]	
Coordination of Benefits	
Benefits for Automobile Related Injuries	
Medicare as Secondary Payor	
Right To Recovery - Third Party Liability	

Statement of ERISA Rights
Claims Procedures

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under the HMO Plan)	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the HMO Plan's Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under this Indemnity Plan)	
Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family] [Note: Must be individually satisfied by 2 separate [Members]] [$750, $1500, $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance **Exception:** For charges for Mental and Nervous Conditions and Substance Abuse treatment	[30%, 20%] **[except as stated below]** 25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS Unlimited, **except** as otherwise stated]

SCHEDULE OF INSURANCE **[PLAN B]**
EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note**: Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500, or $3000]

Hospital Confinement Copayment	
- per day	$200
- maximum Copayment per Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000

Emergency Room Copayment, (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows: 40%

Coinsurance Caps

Per Covered Person per each Calendar Year	$3,000
[Per Covered Family per each Calendar Year	[$6,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]] [$9000]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayment.

SCHEDULE OF INSURANCE **[PLAN C]**
EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500, or $3000]

Emergency Room Copayment (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows: 30%

Coinsurance Caps

Per Covered Person per each Calendar Year	$2,500
[Per Covered Family per each Calendar Year	[$5,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]] [$7500]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE **[PLAN D]**
EMPLOYEE[AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Emergency Room Copayment (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows: 20%, **except as stated below**

Exception: for Mental or Nervous and Substance Abuse charges — 25%

Coinsurance Caps
Per Covered Person per each Calendar Year — $2,000
[Per Covered Family per each Calendar Year — [$4,000, **Note:** Must be individually satisfied by 2 separate Covered Persons]] [$6000]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE **[PLAN E]**
EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible
for Preventive Care — NONE
for immunizations and lead screening for children — NONE
For all other Covered Charges
Per Covered Person — [$150]
[Per Covered Family — [$300] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$450]

Emergency Room Copayment. (waived if admitted within 24 hours) — $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsurance Cap has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows: — 10%, **except as stated below**
Exception: for Mental or Nervous and Substance Abuse charges — 25%

Coinsurance Caps
Per Covered Person per each Calendar Year — $1,500
[Per Covered Family per each Calendar Year — [$3,000. **Note:** Must be individually satisfied by 2 separate Covered Persons]] [$4500]

Note: The Coinsurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
- Copayments.

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (using Plan B, without Copayment)**
EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible
for Preventive Care — NONE
for immunizations and lead screening for children — NONE
for all other Covered Charges

Per Covered Person — [$250, $500 or $1,000]
[Per Covered Family — [$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Hospital Confinement Copayment

- per day	$200
- maximum Copayment par Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000

Emergency Room Copayment, (waived if admitted within 24 hours) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (Using Plan C, with Copayment)**
EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment - If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible - If treatment services or supplies are given by an Out-Network Provider	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Emergency Room Copayment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by an Out-Network Provider	30%

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE INDEMNITY POS (Using Plan D)**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment- If treatment, services or supplies are given or referred by a PCP:

• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible - If treatment services or supplies are given by a Non-referred Provider

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750, $1500 or $3000]

Emergency Room Copayment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Coinsured Charge Limit has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:

• if treatment, services or supplies are given or referred by the PCP	**None, except as stated below**
• if treatment, services or supplies are given by a non-referred Provider	**20%, except as stated below**
Exception: for Mental or Nervous and Substance Abuse charges	
• if treatment, services or supplies are given or referred by the PCP	0%
• if treatment, services or supplies are given by a non-referred Provider	25%

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

SCHEDULE OF INSURANCE (Continued) **[PLAN B]**
Daily Room and Board Limits

During a Period of Hospital Confinement
For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semiprivate room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

• During a Confinement In An Extended Care Center Or Rehabilitation Center
[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care

- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Coinsurance)	
[for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment of Mental or Nervous Conditions and Substance Abuse, per Calendar Year	
Inpatient Confinement	30 days *
Outpatient Care	20 visits

* Unused Inpatient days may be exchanged, on a two-for-one-basis, for additional Outpatient visits.

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

SCHEDULE OF INSURANCE (Continued) **[PLANS C, D, E]**

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

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

• During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a) the center's actual daily room and board charge; or

b) 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer]

- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

SCHEDULE OF INSURANCE (Continued)	**[PLANS C, D, E]**
Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:	
Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Coinsurance) [for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment of Mental or Nervous Conditions and Substance Abuse, per Calendar Year	
Inpatient Confinement	30 days *
Outpatient Care	20 visits
* Unused Inpatient days may be exchanged, on a two-for-one-basis, for additional Outpatient visits.	
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

["DC" THIS INDEMNITY PLAN AND THE ASSOCIATED HMO PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THIS INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THE HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THE HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THIS INDEMNITY PLAN.]

[FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THE HMO PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE COVERED PERSON RECEIVES UNDER THE HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THIS INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THIS INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE COVERED PERSON RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THE HMO PLAN AND THE COVERED CHARGES SECTION OF THIS INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

GENERAL PROVISIONS

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 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS
If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy.

[DIVIDENDS
[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET
[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS
[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW
Any provision of the Policy which, on its Effective Date, is in conflict with the laws of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION
The health benefits provided under the Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;

e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS
[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS
A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout this [certificate], these defined terms appear with their initial letter capitalized.]

[**Actively at Work** or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out it's stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

[Carrier] 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.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

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

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the **Cash Deductible** section of this [certificate] for details.

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

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Charges.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note:** The Emergency Room Copayment, if applicable, must be paid in addition to the Cash deductible, any other Copayments, and Coinsurance.

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee [or a Dependent] who is insured under the Policy.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health 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.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means Your:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time student status will be as defined by the accredited school.

A Dependent is not a person who is:
a) on active duty in any armed forces of any country; or
b) insured for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the Dependent Coverage section of this [certificate].

An Employee's "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children if such step children depend on You for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:
a. the Employee's Eligibility Date; or

b. the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:
a) designed and able to withstand repeated use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful to a Covered Person in the absence of an Illness or Injury; and
d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee[or Dependent].

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

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period.

Experimental or Investigational means [Carrier] determines a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved' by the United States Food and Drug Administration (FDA), [Carrier] 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.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a) Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b) Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c) Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d) Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e) Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is 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 the Policy.

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

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

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

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

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

[**"DC" HMO Plan** means the Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier] in conjunction with this Indemnity Plan.]

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by the Joint Commission or
b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person.

[**"DC" Indemnity Plan** means the Small Employer Health Benefits Policy issued by [Carrier].]

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

Injury means all damage to a Covered Person's body, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

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

Medical Emergency means 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. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

A near term delivery is not a Medical Emergency.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

Mental or Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

[**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavior 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 "Behavior Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

DEFINITIONS (Continued) **[PLAN B]**

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:
a) as an Employee [or Dependent]; and
b) with or without interruption of coverage.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this (certificate] to "Policy" should be changed to read "Plan"]

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"]

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

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

["DC". **Point of Service Plan** (Often referred to as a POS plan) means a plan that provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary

authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

DEFINITIONS (Continued) **[PLANS C,D,E]**

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such settings.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"]

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"]

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

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

["DC" Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
b) [• the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the 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 means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the Schedule of Insurance contained in the Policy and in this [certificate].

Skilled Nursing Care means 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 (see Extended Care Center.)

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

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

Substance Abuse means abuse of or addiction to drugs.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means:
a) the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;

c) Reasonable and Customary pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as Surgery.

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

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

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

[We, Us, Our and **[Carrier]** mean **[Carrier].]**

[You, Your and Yours mean an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

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

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's Conditions of Eligibility.

Conditions of Eligibility

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

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

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

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

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

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

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

[The Waiting Period
The Policy has the following waiting periods:

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

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

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

When Employee Coverage Starts
[Except where You are not Actively at Work due to a Health Status Related Factor, and except as stated below,]You must be [Actively at Work, and]working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. [If You are not Actively at Work on the scheduled Effective Date and do not qualify for the exception to the actively at Work requirement, [Carrier] will postpone the start of Your coverage until You return to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.]

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

If You do this more than [30] days after Your Eligibility Date, [Carrier] will consider You a Late Enrollee. Coverage is scheduled to start on the date You sign the enrollment form.

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

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

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:
a) [the date] You cease to be [an Actively at Work][a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] You stop being an eligible Employee under the Policy.
c) the date the Policy ends, or is discontinued for a class of Employees to which You belong.
d) the last day of the period for which required payments are made for You, subject to the **Payment of Premiums - Grace Period** section.

["DC" e) [the date] You cease to be covered under the associated HMO Plan.]

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are Your:
a) legal spouse;
b) unmarried Dependent children who are under age 19; and
c) unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:
a) on active duty in any armed forces of any country; or
b) insured for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the Incapacitated Children section of this [certificate].

Your "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children if such step children depend on You for most of their support and maintenance, and
c) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached the Policy's age limit;
b) the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and
c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Policy. ["DC" Only eligible Dependents who You include for coverage under the associated HMO Plan may be enrolled under this Indemnity Plan.] [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage `previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

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

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;

c) involuntary termination;;
d) divorce or legal separation;
e) death of Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:
a) You are under legal obligation to provide coverage due to a court order; and
b) You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

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

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

When Dependent Coverage Starts
In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date You sign the enrollment form; or
b) the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

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

If the Policyholder who purchased the replacement Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date the replacement Policy takes effect will initially be eligible for limited coverage under the replacement Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the replacement Policy takes effect immediately upon termination of the prior plan.

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

Newborn Children
[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:
I. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, [provided the premium required for Dependent child coverage continues to be paid.] [and, the Employee must notify [Carrier] of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
II. If You are not covered for Dependent child coverage on the date the child is born, You must:
A. make written request to enroll the newborn child; and
B. pay the premium required for Dependent child coverage within 31 days after the date of birth.

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

When Dependent Coverage Ends:
A Dependent's insurance under the Policy will end on the first of the following dates:
a) [the date] Your coverage ends;
b) the date You stop being a member of a class of Employees eligible for such coverage;
c) the date the Policy ends;
d) the date Dependent coverage is terminated from the Policy for all Employees or for Your class.
e) the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.
f) at 12:01 a. m. on the date the Dependent stops being an eligible Dependent.
["DC" g) the date the Dependent ceases to be covered under the associated HMO Plan.]

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]
The 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 [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[Note: Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions
a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply Covered Person with a list of PCPs who are members of the [~Z] Provider Organization..
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d) ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [~Z] Provider Organization.

Provider Organization (PO)
The Provider Organization for the Policy is the [~Z] Provider Organization. The Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [~Z] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services
If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

In the case of a Medical Emergency, a Covered Person may go to a [XYZ 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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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.

Utilization Review
The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits
The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[Note: Used only if coverage is offered as Indemnity POS.]

APPEALS PROCEDURE

Carrier may elect to include an appeal 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 Departments of Banking and Insurance and Health, it may include that approved Appeal Procedure language in the standard SEH forms.

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible
Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.]

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

[Coinsurance Cap
This Policy limits Coinsurance amounts each Calendar Year **except** as stated below. The Coinsurance Cap cannot be met with:
a) Non-Covered Charges;
b) Cash Deductibles;
c) Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse; and
d) Copayments.

There are Coinsurance Caps for:
a) each Covered Person;[and
b) each Covered Family.]

The Coinsurance Caps are shown in the Schedule.

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance Cap. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.]

[Once the Covered Person's Coinsurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Coinsurance for the rest of that Calendar Year.]

[Once two Covered Persons in a family meet their individual Coinsurance amounts, [Carrier] will waive the family's Coinsurance for the rest of that Calendar Year.]

[Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Coinsurance Caps equal to the Per Covered Family Coinsurance Caps, each Covered Person in that family will be considered to have met his or her Per Covered Person Coinsurance cap for the rest of that Calendar year.]

[Exception: Charges for Mental or Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Coinsurance Cap.]

[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.]**

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person's being covered by 2 or more plans or policies. Read the provision Coordination of Benefits to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the Medicare as Secondary Payor section for an explanation of how this works.

If This Plan Replaces Another Plan
The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other carrier.

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

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:

a) the Employee was employed by the Employer on the date the Employer's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

Extended Health Benefits
If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

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

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

HEALTH BENEFITS INSURANCE (Continued) **[PLAN B]**
COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges
[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an **exception** to the Medically Necessary and appropriate requirement of the Policy, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by [Carrier].]

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this [certificate's] Emergency Room Copayment Requirement section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Copayment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Copayment per Calendar Year.

HEALTH BENEFITS INSURANCE (Continued) **[PLANS C,D,E]**

COVERED CHARGES
This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges
[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an **exception** to the Medically Necessary and appropriate requirement of the Policy, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by [Carrier].]

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

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

Pre-Admission Testing Charges
[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges
Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.
But [Carrier] limits what [Carrier] will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this [certificate].

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.
["DC" NOTE: ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

Home Health Care Charges:
Subject to [Carrier's] Pre-Approval, when home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the 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. the Covered Person's 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 the Covered Person's 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. 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.

3. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
4. 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.
5. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment
[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this [certificate].

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

[Carrier] covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges
[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse
[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy
The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges
[Carrier] covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]
["DC" NOTE: ANY NEWBORN CHILD SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

Anesthetics and Other Services and Supplies
[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood
[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges
[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:
a) any purchases without [Carrier's] advance written approval;
b) replacements or repairs; or
c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor
[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of the Policy.

Nutritional Counseling
Subject to [Carrier] Pre-Approval, [Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which are not Pre-Approved by [Carrier] are Non-Covered Charges.

X-Rays and Laboratory Tests
[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this [certificate's] Preventive Care section, [Carrier] does not pay for x-ray's and tests done as part of routine physical checkups.

Prescription Drugs
[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.
Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.
In no event will [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier]] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does 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 the Policy.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment

[Carrier] covers:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury occurs while the Covered Person is 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 does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthestic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of the Policy, and the following limitations:

[Carrier] will cover charges for:

a) one baseline mammogram for a female Covered Person, ages 35 - 39
b) one mammogram, every 2 years, for a female Covered Person, ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female Covered Person ages 50 and older.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies Issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is an adopted child or, who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method][[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] only covers 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 a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a) *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b) *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c) *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d) *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e) *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f) *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
g) Speech *Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, combined, is limited to 30 visits per Calendar Year.

h) *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
i) *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

j) *Infusion Therapy* - subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.
["DC" NOTE: ANY THERAPY SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPY BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Fertility Services

Subject to [Carrier] Pre-Approval, [Carrier] covers charges for procedures and prescription drugs to enhance fertility.

Charges in connection with Fertility Services which are not Pre-Approved by [Carrier], or which are specifically excluded, are Non-Covered Charges.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to:
a) [$500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and]
b) $300 per Covered Person for all [other] Covered Persons.

These charges are not subject to the Cash Deductible or Coinsurance.
["DC" NOTE: ANY PREVENTIVE CARE SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE UNDER THE INDEMNITY PLAN.]

Immunizations and Lead Screening
[Carrier] will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Vision Screening
[Carrier] covers eye examinations for Dependent children, through age 17, to determine the need for vision screening.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge
["DC" NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Mental or Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental or Nervous Conditions and Substance Abuse. [Carrier] includes a condition under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits coverage for all treatment of Mental or Nervous Conditions and Substance Abuse per Calendar Year to:
a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.
One or more of any unused Inpatient days may be exchanged on a two-for-one-basis for additional Outpatient visits.

[Carrier] does not pay for Custodial Care, education, or training.
["DC" NOTE: ANY MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

Transplant Benefits
[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID

- WISCOT Alldrich
- **Subject to [Carrier] Pre-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 [Carrier] are Non-Covered Charges.]**

h) [Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under- these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See **the Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate], You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:
a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means (Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than (60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, by 50%] if:

a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges by 50%], if:

a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.] [Coinsured Charge Limit.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from (ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from (a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC],]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:
a) Cash Deductible; or
b) [Coinsurance Caps.] [Coinsured Charge Limit.]

[ALTERNATE TREATMENT FEATURES

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

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
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 20o/o or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

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

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Carrier].

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d) estimated cost and savings.

If [Carrier], [DEF], 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.

Exclusion
Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] 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 Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery***, except as otherwise stated in the Policy; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances, except as otherwise stated in the Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment by means of ***dose intensive chemotherapy***, except as otherwise stated in the Policy.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in the Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or

c) eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygotr Intra-fallopian Transfer (ZIFT); and drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related to ***Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

["DC" Services or supplies provided under the associated ***HMO Plan.***]

Services or supplies related to ***Hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

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

Services and supplies related to ***Marriage, career or financial counseling,*** sex therapy or family therapy, nutritional counseling and related services, except as otherwise stated in the Policy.

Supplies related to ***Methadone*** maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the **Preventive Care** section of the Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.

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

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this [certificate].

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the **Preventive Care** section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care except:***
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and

c) treatment or removal 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 on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker***, except as otherwise stated in the Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and / or treatment, and the travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
- Subject to [Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time student status in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS
COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:
a) Your Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under the Policy during a continuation provided by this section is not qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:
a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:
a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours or during the first 60 days of continuation coverage, You and any qualified continuee who is not disabled may elect to extend the 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and
b) days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If You die, while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Your Dependents who become entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon Your subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of Your termination of employment or reduction in work hours; or
b) 36 months from the date of Your earlier entitlement to Medicare.

Exception: If You become entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:

a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue the Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hour; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a) the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within, 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is not longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date the Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses section for details.**

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End
If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the When Continuation Ends section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. If You acquire one or more Dependents after the continued health coverage begins, You may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify You, in writing, of:
a) Your right to continue the Policy's group health benefits;
b) the monthly premium You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends
A Covered Person's continued health coverage end on the first of the following:

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the Covered Person becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e) with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

lithe Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if You stop paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Policy ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

A EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:
a) Your Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to You.

If An Employee's Group Health Coverage Ends
Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date You return to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a) 180 days following the date of Your death; or

b) the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See exceptions below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy ["DC" ,where this Indemnity Plan is issued in conjunction with an HMO Plan. This Effect of Interaction with a Health Maintenance Organization Plan provision does **not** apply to Employees and their Dependents who are HMO members due to coverage under this Indemnity Plan and the associated HMO Plan.] If the Employer does ["DC" offer HMO membership under an HMO plan *other than* the associated HMO Plan], the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends
Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends
When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 90 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in] the HMO service area

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, You and Your her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent
If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, You and Your her Dependents will be Late Enrollees.

request made at any other time
You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions, to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit
The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health benefits by more than one plan. ["DC" For the purpose of this Coordination of Benefits and Services Provision, coverage under this Indemnity Plan and the associated HMO Plan constitutes coverage under only one plan. There will not be any Coordination of Benefits and Services between the Indemnity Plan and the associated HMO Plan under this provision.] For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d) programs or coverages required by law; or
e) Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) any group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance; nor
f) any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate 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 plan or any other plan. 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, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide 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 plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works
[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:
a) A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c) Except for Dependent children of separated or divorce parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information
In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action;

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver
[Carrier] does 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 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;
caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) the Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.
If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.
If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the Coordination of Benefits section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the When The Policy is Primary section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the When Medicare is Primary section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary
When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a Covered Person who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.'

If a Covered Person is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits** section of the Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits** section of the Policy.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"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 [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] 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.

[Carrier] 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 [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not provide benefits under the 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.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should *be* returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c) If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).

EXHIBIT X

(RESERVED)

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT Y

[Carrier]

HMO PLAN
SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
EVIDENCE OF COVERAGE

[[Carrier] certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.]

[The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.]

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER: [G-12345]

[EMPLOYEE: [John Doe]]

[CERTIFICATE NUMBER: [C-123456]]

EFFECTIVE DATE OF EVIDENCE OF COVERAGE: [January 1, 1998]

[COVERED CLASSES:
[All Employees of the Contractholder (and its Associated Companies) who permanently reside in the Service Area and are eligible or covered under the Group Care Health Plan.]]

SERVICE AREA: [The State of New Jersey]

AFFILIATED COMPANIES: [DEF Company]

COST OF THE COVERAGE:
[The coverage in this Evidence of Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll.]

[HMO's Address: [400 Main Street
Chester, New Jersey 00000]

This Evidence of Coverage replaces any older Evidence of Coverage issued to You for the Group Health Care Plan.

[Secretary President]

["DC" THIS SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS HMO PLAN AND THE INDEMNITY PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under this HMO Plan)	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under the Indemnity Plan)	
Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family][Note: Must be individually satisfied by 2 separate [Members]] [$750, $1500, $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] [**except as stated below]**
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS Unlimited, **except** as otherwise stated]

SCHEDULE OF SERVICES AND SUPPLIES

THE SERVICES OR SUPPLIES COVERED ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	COPAYMENTS[/COINSURANCE]:
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$50 Copayment/visit/[Member] (credited toward Inpatient Admission if Admission occurs within 24 hours)
SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	$15 Copayment/visit
HOME HEALTH CARE	Unlimited days, if preapproved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if preapproved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	$25 Copayment for initial visit only; $0 Copayment thereafter.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE:	
OUTPATIENT	$15 Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment: $1,500/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	$15 Copayment/visit; maximum 30 visits/Calendar Year
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CENTER	Unlimited days, if preapproved; $0 Copayment.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	$15 Copayment/visit

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

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

["DC" THIS HMO PLAN AND THE ASSOCIATED INDEMNITY PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THE INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THIS HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THIS HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THE INDEMNITY PLAN.]

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

DEFINITIONS

The words shown below have specific meanings when used in this Evidence of Coverage. Please read these definitions carefully. Throughout the Evidence of Coverage, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services are provided under the Group Health Care Plan.

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

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

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

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

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

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

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

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

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

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a [Member.] Coinsurance does not include Copayments.]

CONTRACT. The contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier] which defines the terms and conditions under which the [Carrier] agrees [to provide or arrange] health care for the Employer's Employees [or members].

CONTRACTHOLDER. Employer or organization which purchased the Contract.

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

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

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

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Evidence of Coverage.

Read the entire Evidence of Coverage to find out what We limit or exclude.

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

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

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

Even if a Covered Person is in a Hospital or other recognized Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT.
Your:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section.

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

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

A Dependent is not a person who is covered by the Group Health Care Plan as an Employee.

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a[Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a[Member]'s home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Group Health Care Plan for a [Member].

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

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies which We Determine are:

a) not of proven benefit for the particular diagnosis or treatment of a[Member]'s particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a[Member]'s particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a[Member]'s particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a[Member]'s particular condition, as explained below.

We 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:

I. The American Medical Association Drug Evaluations;
II. The American Hospital Formulary Service Drug Information; or
III. The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

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

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

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

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network][Participating] Providers provide Covered Services and Supplies to [Members].]

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

GROUP HEALTH CARE PLAN. The plan of health care coverage described in this Evidence of Coverage which a Contractholder is providing for its Employees[or members].

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.

["DC" HMO PLAN. The Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier].]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all *relevant* state and local laws, and it must either:
a) be accredited as a hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

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

["DC" INDEMNITY PLAN. The Small Employer Health Benefits Policy issued by [Carrier] in conjunction with this HMO Plan.]

[INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.]

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

INPATIENT. [Member] if physically confined as a registered bed patient in a Hospital or other 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.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under the Group Health Care Plan more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** [and **Dependent Coverage]** subsections of the Eligibility section appearing on later pages.

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

A near-term delivery is not a Medical Emergency.

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

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a[Member]'s convenience;
e) the most appropriate level of medical care that a[Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-Participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee [and covered Dependents, if any)].

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

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

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

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

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.]

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in this Evidence of Coverage.

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

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

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

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

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

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

[**"DC" POINT OF SERVICE PLAN.** Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [network] providers under an HMO plan as well as the services of [out-of-network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [out-of-network] provider. [Out-of-network] charges are usually greater than the [network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Reasonable and Customary Charge for a service or supply.]

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

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

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

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

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

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre- and post-natal care, birth and treatment of the diseases and hygiene of females,] or

pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized Facility or practitioner of health care.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that directs a [Member] to a Facility or Provider for health care.

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

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

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

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

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

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

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

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

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

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Employee.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Group Health Care Plan, all of the Contractholder's Employees[who are in an eligible class and] who reside in the Service Area will be eligible if ["DC"
a)]the Employees are [Actively at Work] Full-Time Employees[.]["DC" and;
b) the Employees enroll under the associated Indemnity Plan.]
[In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

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

Conditions of Eligibility

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

Enrollment Requirement
We will not cover You until You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee Eligibility Date, coverage will start on Your Employee Eligibility Date.

If You enroll and agree to make the required payments, if any:
a) more than [30] days after Your Employee Eligibility Date; or
b) after You previously had coverage which ended because You failed to make a required payment,

We will consider You to be a Late Enrollee. Late Enrollees are subject to this Group Health Plan's Pre-Existing Conditions limitation.

When an Employee initially waives coverage under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If You initially waived coverage under the Group Health Care Plan, and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under this Group Health Care Plan, We will not consider You [and Your Dependents] to be [a] Late Enrollee[s], provided the coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation;
e) death of Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll under this Group Health Care Plan within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

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

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

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

[The Waiting Period
The Group Health Care Plan has the following waiting periods:

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

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

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

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

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

When Employee Coverage Starts
[Except where You are not Actively at Work due to a Health Status Related Factor, and except as stated below,] You must be [Actively at Work, and] working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. [If You are not Actively at Work on the scheduled Effective Date, and do not qualify for the Exception to the Actively at Work requirement, We will postpone the start of Your coverage until You return to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working
Your regular number of hours, on Your last regularly scheduled work day.]

You must elect to enroll and agree to make the required payments if any, within [30] days of Your Employee Eligibility Date. If You do this within [30] days of the Employee Eligibility Date, Your coverage is scheduled to start on Your Employee Eligibility Date. Your Employee Eligibility Date is the scheduled Effective Date of Your coverage.

If You do this more than [30] days after Your Eligibility Date, We will consider the You a Late Enrollee. Coverage is scheduled to start on the date You sign the enrollment form.

[EXCEPTION to the Actively at Work Requirement

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

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

When Employee Coverage Ends
Your coverage under the Group Health Care Plan will end on the first of the following dates:
a) You cease to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) You stop being an eligible Employee under the Group Health Care Plan.
c) the date this Group Health Care Plan ends, [or is discontinued for a class of Employees to which You belong.]
d) for which required payments are not made for You, subject to the **Payment of Premium - Grace Period** section..
e) [You move Your permanent residence outside the Service Area.]
["DC" f) [the date] an Employee ceases to be insured under the associated Indemnity Plan.]

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This Evidence of Coverage's continuation provisions explain these situations. Read these provisions carefully.

[DEPENDENT COVERAGE

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

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

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

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

Incapacitated Children
You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Group Health Care Plan, such a child may stay eligible for Dependent health benefits past this Group Health Care Plan's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached this Group Health Care Plan's age limit;
b) the child depends on You for most of his or her support and maintenance; and
c) the child became covered by the Contract or any other policy or contract before the child reached the age limit and stayed continuously covered after reaching such limit.

But, for the child to stay eligible, You must send Us written proof that the child is handicapped and depends on You for most support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when Yours does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Group Health Care Plan. ["DC" Only eligible Dependents who the Employee includes for coverage under the associated Indemnity Plan may be enrolled under this HMO Plan.] We consider an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Group Health Care Plan's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

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

But, Your spouse or eligible Dependent children must be enrolled by You within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs

And, [Carrier] will not consider an Your spouse or eligible Dependent children for which You initially waived coverage under the Group Health Care Plan, to be a Late Enrollee, if:
a) You are under legal obligation to provide coverage due to a court order; and
b) Your spouse or eligible Dependent children are enrolled by You within 30 days of the issuance of the court order.

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

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

When Dependent Coverage Starts
In order for Your dependent coverage to begin You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time.
Subject to all of the terms of the Group Health Care Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents.

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

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

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

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

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

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

Newborn Children
We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:
a) If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.] [and the Employee must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If You are not covered for Dependent child coverage on the date the child is born, You must •make written request to enroll the newborn child.

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

When Dependent Coverage Ends:
A Dependent's coverage under the Group Health Care Plan will end on the first of the following dates:
a) Your coverage ends;
b) the date the Group Health Care Plan ends;
c) the date Dependent coverage is dropped from the Group Health Care Plan for all Employees eligible for such coverage;
d) the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.
e) At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.
f) [with respect to a Spouse, the date the Spouse moves his or her permanent residence outside the Service Area.]
["DC" g. the date the Dependent ceases to be insured under the associated Indemnity Plan.]

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

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

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

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

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

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

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Group Health Care Plan:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the[Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any identification card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.

d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under the Group Health Care Plan immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the coverage after that date.

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

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

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

["DC" Note: Under the terms of the associated Indemnity Plan, there is no requirement that the Member contact a Primary Care Physician to access services or supplies, but all benefits are subject to the terms and conditions of the associated Indemnity Plan.]

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

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

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

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

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

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration

of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [PARTICIPATING] SERVICES AND SUPPLIES
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Participating] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Participating] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Participating] Practitioner. If such [Participating] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Participating] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences ["DC" under this HMO Plan]. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding position of the [Participating] Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the [Member] asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate this Contract in accordance with the General Provisions. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the [Participating] Practitioner will cooperate with the [Member] in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT
A [Member] has the right under New Jersey law to refuse life sustaining treatment. A [Member] who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS
We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY
[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate [Participating] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

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

d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION ON SERVICES
Except in cases of Medical Emergency, services ["DC" under this HMO Plan] are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a[Member] from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

COVERED SERVICES & SUPPLIES

["DC" Under this HMO Plan,] [Members] are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable copayments [or Coinsurance] as stated in the applicable Schedule of Services and Supplies.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior written Referral by a [Member]'s Primary Care Physician [or Health Center] [or the Care Manager]:
1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by a [Member]'s Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member]'s employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by a [Member]'s Primary Care Physician and approved in advance by Us.
7. **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in this Contract.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and of a natural part of a [Member]'s body, or be needed due to a functional birth defect in a Appropriate), repairs, wigs, or dental prosthetics or devices.
9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Physician and arranged through Us.
10. **Prescription Drugs and contraceptives which require a Practitioner's prescription,** and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.
    A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the [Member's] Participating Provider.
    A supply will be considered to be furnished at the time the Prescription Drug is received.
11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and approved in advance by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

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

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval:
1. Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
a) up to 48 hours of inpatient care in a Participating Hospital following a vaginal delivery; and
b) a minimum of 96 hours of inpatient care in a Participating Hospital following a cesarean section.
We provide such coverage subject to the following:

a) the attending Practitioner must determine that inpatient care is medically necessary; or
b) the mother must request the inpatient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.
[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the[Member] is participating in a National Cancer Institute sponsored clinical trial.]
[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

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

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member]'s Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services(such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member]'s Primary Care Physician [or the Care Manager], for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** [Members]are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.
["DC" NOTE: ANY MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered ["DC" under this HMO Plan] without prior written referral by a [Member]'s Primary Care Physician in the event of a Medical Emergency as Determined by Us.

1. A [Member]'s Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
a. Our review determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-emergency basis; and
c. We and the [Member]'s Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event [Members] are hospitalized in a Non-Participating Facility, coverage will only be provided until [Members] are medically able to travel or to be transported to a Participating Facility. If [Members]elect to continue treatment with Non-Participating Providers, We shall have no responsibility for payment beyond the date [Members] are Determined to be medically able to be transported.
In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the reasonable and customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written referral to a Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or [Members] shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

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

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

2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy, and Respiration Therapy.
["DC" NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPY SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

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

1. **Skilled nursing services,** provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide,** under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to the [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a[Member]'s medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member]'s Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

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

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Participating] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THE GROUP HEALTH CARE PLAN.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner**.

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in this Evidence of Coverage; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Evidence of Coverage.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the [Member] with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, Services or supplies related to **Hearing aids** and hearing examinations to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Services or supplies related to **Hypnotism.**

Services or supplies necessary because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

["DC" Services or supplies for which benefits are paid under the associated **Indemnity Plan**.]

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

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

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Evidence of Coverage, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:
The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under the Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that

category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under the Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under the Contract starts. If the Employer has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.]

Any service provided without prior written Referral by the [Member's] **Primary Care Physician** except as specified in this Evidence of Coverage.

In the event of a Medical Emergency, the amount of any charge which is greater than the amount We Determine to be the **reasonable and customary charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care, except:**

a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member]'s sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

APPEAL PROCEDURE

[Appeal Procedure: Variable by Carrier as approved by the State of New Jersey.]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A [Member] may be covered for health benefits or services by more than one plan. ["DC" For the purpose of this Coordination of Benefits and Services Provision, coverage under this HMO Plan and the associated Indemnity Plan constitutes coverage under only one plan. There will not be any Coordination of Benefits and Services between the HMO Plan and the associated Indemnity Plan under this provision.] For instance, he or she may be covered by this Group Health Care Plan as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

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

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

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works
We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:
a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

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

Our Right To Certain Information
In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

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

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are provided as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the[Member] is insured or covered for services under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

ASSIGNMENT
No assignment or transfer by a [Member] of any of his or her interest under this Group Health Care Plan is valid unless We consent thereto.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Group Health Care Plan.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

In the event this Contract is amended, and such amendment affects the material contained in the evidence of coverage, a rider or revised evidence of coverage reflecting such amendment will be issued to the Contractholder for delivery to affected Employees.

GOVERNING LAW
This entire Group Health Care Plan is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Group Health Care Plan shall be used in contesting the validity of his or her coverage or in deny benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to a Member: 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 services and supplies to the extent stated in the 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 Group Health Care Plan.

We reserve the right to modify or replace an erroneously issued Evidence of Coverage.

Information in a [Member's] application may not be used by Us to void the Contract or in any legal action unless the application or a duplicate of it is attached to the Contract or has been mailed to a Member.

CONTRACT INTERPRETATION
We shall administer Group Health Care Plan 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 the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the [Member] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION
The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS
As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of the Group Health Care Plan at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)**: If a[Member] is eligible to continue his or her group health benefits under both the Group Health Care Plan's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of the Group Health Care Plan:

If a [Member] elects to continue his or her group health benefits under both the Group Health care Plan's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. You must contact Your Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Group Health Care Plan as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Your Group Health Benefits Ends
If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:
a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:
a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from You by the Employer during this extra 11 month continuation period.

If You Die While Covered
If You die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If Your Marriage Ends
If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Group Health Care Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in This Group Health Care Plan, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue the Group Health Care Plan's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
• the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
•the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date the Contract ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Evidence of Coverage's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If Your Group Benefits End
If Your health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. If You acquire one or more Dependents after the continued health coverage begins, You may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for Your Dependents, the You must elect to continue health coverage for Yourself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:
a) his or her right to continue This Group Health Care Plan's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What You Must Do
To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

The subsequent premiums must be paid to the Employer, by You, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
Your continued coverage will be identical to the coverage You had when covered under this Group Health Care Plan on a regular basis. Any modifications made under this Group Health Care Plan will apply to similarly situated continuees. We do not ask for proof of insurability in order for You to continue.

When Continuation Ends
A [Member]'s continued health coverage ends on the first of the following:
a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the [Member];
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the [Member], the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in This Group Health Care Plan.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You Are Totally Disabled
If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been covered by this Group Health Care Plan for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under this Group Health Care Plan would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under this Group Health Care Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if You stop paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c) the date this Group Health Care Plan ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Group Health Care Plan.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If Your Group Health Coverage Ends
Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date You return to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period;
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were covered under this Group Health Care Plan may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:
a) days following the date of Your death; or
b) the date the Dependent is no longer eligible under the terms of this Group Health Care Plan.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS
If Your marriage ends by legal divorce or annulment, the group health coverage for Your former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Group Health Care Plan on the date the group health coverage ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) unless he or she has been covered under this Group Health Care Plan for at least 3 months;
b) if he or she is eligible for Medicare;
c) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if excessive coverage exists using Our standards for excessive coverage. or
d) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Group Health Care Plan ends.

After group health coverage under This Group Health Care Plan ends, the former spouse and any children covered under the individual contract may still receive benefits under this Group Health Care Plan. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Group Health Care Plan.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Group Health Care Plan.
"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.
"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Group Health Care Plan prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Group Health Care Plan or arrange [or provide] services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and This Group Health Care Plan will be the secondary health plan for [Members] who are eligible for Medicare. Benefits will be payable as specified in the COORDINATION OF BENEFITS AND SERVICES section of the Contract.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **COORDINATION OF BENEFITS AND SERVICES** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or

c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When This Group Health Care Plan is primary
When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under the Contract will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a [Member] who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Group Health Care Plan and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.

b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.

c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT Z
CARD/MAIL
SEH-OR-EB-1A
RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
Group Policy No:
Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   - The American Medical Association Drug Evaluations;
   - The American Hospital Formulary Service Drug Information;
   - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

Drugs provided on an Outpatient basis for the treatment of Mental or Nervous Conditions and Substance Abuse are covered under this Rider for Prescription Drug Insurance. Drugs provided on an Inpatient basis to treat Mental or Nervous Conditions and Substance Abuse, however, are not covered under this Rider for Prescription Drug Insurance or the Prescription Drugs Covered Charge of the Policy. Rather, drugs for such Inpatient treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Policy.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:
• for Generic Drugs $5.00
• for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:
• for Generic Drugs NONE
• for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will he liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c) Charges for a Prescription Drug which is:
- labeled "Caution - limited by Federal Law to Investigational use"; or
- experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h) Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental Fluorides.
l) Charges for any drug used in connection with baldness.
m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-EB-1B
RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
Group Policy No:
Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

Drugs provided on an Outpatient basis for the treatment of Mental or Nervous Conditions and Substance Abuse are covered under this Rider for Prescription Drug Insurance. Drugs provided on an Inpatient basis to treat Mental or Nervous Conditions and Substance Abuse, however, are not covered under this Rider for Prescription Drug Insurance or the Prescription Drugs Covered Charge of the Policy. Rather, drugs for such Inpatient treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Policy.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:
• for Generic Drugs $5.00
• for Brand Name Drugs $10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a. prescribed by a Practitioner (except for insulin)
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a. the greater of a 30 day supply or 100 unit doses; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
• immunization agents
• biological sera
• blood or blood plasma.
c) Charges for a Prescription Drug which is:
• labeled "Caution - limited by Federal Law to Investigational use"; or
• experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner.

e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.
h) Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.
i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental Fluorides.
l) Charges for any drug used in connection with baldness.
m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-EB-1C
RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
Group Policy No:
Effective Date:]

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:
• for Generic Drugs NONE
• for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a. prescribed by a Practitioner (except for insulin)
b. dispensed by a Participating Mail Order Pharmacy for take-home use; and
c. needed to treat an Illness or Injury.

Such charges will not include charges made for more than:
a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c) Charges for a Prescription Drug which is:
- labeled "Caution - limited by Federal Law to Investigational use"; or
- experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center

- a convalescent home
- a nursing home

or similar institution.

h) Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental Fluorides.
l) Charges for any drug used in connection with baldness.
m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

SEH-OR-EB-2
RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

[Policyholder:
Group Policy No:
Effective Date:]

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a) drugs labeled: "Caution' - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the Penalty for Non-Compliance with Pre-Certification Requirements section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a) the Medical Necessity and Appropriateness;
b) the type of service involved;
c) the appropriate level of care required; and
d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co- Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:
a) days of Inpatient care per Calendar year; and
b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a) the Covered Person does not request a review in the times and manner described above;
b) the Covered Person's treatment does not comply with the treatment plan;
c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
d) [XYZ] does not confirm the need for such care or treatment.

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

[Carrier should inset Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT AA

CARD/MAIL (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program:
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.
[Carrier should insert Standard Rider Closure]

CARD (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin, insulin needles and insulin syringes; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.

h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure]

MAIL (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Evidence of Coverage is supplemented with the following:

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Mail Order Pharmacy;
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.

q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT BB
PART 1
CERTIFICATION OF COMPLIANCE WITH SMALL EMPLOYER HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:21-4.2, submit this form, by March 1 of every year, in triplicate to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and one copy to the New Jersey Department of Banking and Insurance as follows: Attn: SEH Form Certification of Compliance, Office of Life and Health Actuaries, N.J. Department of Banking and Insurance, 20 West State Street, CN 325, Trenton, NJ 08625-0325. 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 # _____

If an HMO, is the Carrier Federally qualified?

_____ Yes _____ No

Respondent's Name: _____

Respondent's Title: _____

Respondent's Address: _____

_____

Respondent's Telephone: _____ FAX: _____

2. COMPLIANCE

Check the appropriate response(s).

_____(a) Plans A, B, C, D and E comply fully with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(b) Plans A, B, C, D and E comply with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21, BUT an alternative method of utilization review, as permitted at N.J.A.C. 11:21–4, is being submitted for review and approval or has already been approved by the SEH Board.

_____(c) HMO Plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of brackets set forth at Exhibit G and K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(d) The HMO/POS plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibits HH and JJ of the Appendix to N.J.A.C. 11:21, and the HMO is in compliance with Department of Health and Senior Services regulations governing an HMO's ability to offer out-of-network services set forth at N.J.A.C. 8:38–14.

_____(e) All standard riders applicable to Plans A through E comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth in Exhibits H, and I and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(f) All standard riders applicable to HMO Plan and HMO/POS Plan comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth at Exhibit J and K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(g) All applications, certifications, enrollment forms, waiver forms, certificates or evidence of coverage comply with the SEH Board's forms set forth in Exhibits N, O, Q, R, S, T, V, W, Y, Z, AA, and II and the explanation of Brackets set forth at Exhibit X and JJ in the Appendix to N.J.A.C. 11:21.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section (please use "NA" to indicate when a section is not relevant). Attach additional pages as necessary.

(a) Plans A through E (To be completed by non-HMO carriers)

(1) Identify the standard plans offered as a traditional contract:

Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___

(2) Identify the standard plans offered in conjunction with a selective contracting arrangement* (defined at N.J.A.C. 11:4–37):

PPO Plans:

Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___

Indemnity POS Plans:

Plan C:___ Plan D:___ Plan E:___

*A carrier must first have received approval of its selective contracting arrangement by the Departments of Health and Insurance before it may issue standard small employer plans through such an arrangement. Note: Some carriers may not be subject to the statute and regulations relating to selective contracting arrangements. Such carriers should note the plans that they are offering as if they were subject to selective contracting regulations.

(3) For all plans offered in conjunction with a selective contracting arrangement, specify the in network and out-of-network benefit levels in the space provided next to the plan (e.g., Plan D: 100%/80%), indicate whether the plan requires election of a primary care physician, and indicate the copay options available.

PPO Plans:

Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___

Copay:___ Copay:___ Copay:___ Copay:___ Copay:___

Indemnity POS Plans:

Plan C:___ Plan D:___ Plan E:___

PCP:__ PCP:__ PCP:____

Copay:___ Copay:___ Copay:___

(4) Do contracts provide for direct payment to health care practitioners without assignment? (Note: this option is available only on health service corporation contracts and other plans offered in conjunction with selective contracting arrangements.)

_____ Yes _____ No

(5) Indicate whether any standard riders are offered, if any, and specify the plans with which they will be offered.

Prescription Drug–Card/Mail: _____

Offered with Plans: _____

Prescription Drug–Card: _____

Offered with Plans: _____
Prescription Drug–Mail: _____
Offered with Plans: _____
Mental and Nervous Conditions/Substance Abuse: _____
Offered with Plans: _____

(6) If offering the Mental/Nervous and Substance Abuse rider, indicate the applicable copayments.

_____
_____
_____
_____

(7) Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
_____ Yes _____ No
If No, has the Board approved the carrier's use of an alternate participation requirements?
_____ Yes _____ No
Do the plans include a dependent participation requirement?
_____ Yes _____ No

(8) Do the plans include any of the following as set forth by the SEH Board?

i. Utilization Review Features
_____ Yes _____ No
If No to the Utilization Review Feature, is an alternate method of utilization review included in the Plans?
_____ Yes _____ No
If Yes, is it included with this submission?
_____ Yes _____ No

ii. Required Hospital Stay Review
_____ Yes _____ No

iii. Required Pre-surgical Review
_____ Yes _____ No

iv. Alternate Treatment Features
_____ Yes _____ No

v. Centers of Excellence Features
_____ Yes _____ No

vi. Grievance Procedures
_____ Yes _____ No

(9) Specify how the Family Deductible and Family Coinsurance Caps are being offered. (See N.J.A.C. 11:21–3.1(b))
_____ Individual basis; or
_____ Aggregate basis

(10) Specify how coverage for autologous bone marrow transplants is offered.

(i) Plan A selection:
_____ Plan benefit; or
_____ Rider benefit

(ii) Plan B through E selection:
_____ Plan benefit; or
_____ Rider benefit

HMO Plan (To be completed by HMO carriers)
HMO Contracts:

(1) List the copayment options being offered.
___$5 Copay ___$10 Copay ___$15 Copay ___$20 Copay

(2) How is the in-plan prescription drug coverage being offered?
___$15 Copay ___50% Coinsurance

(3) Specify the standard riders being offered, if any, and specify the plan with which they will be offered.
Prescription Drug–Card/Mail: _____
Offered with Plans: _____
Prescription Drug–Card: _____
Offered with Plans: _____
Prescription Drug–Mail: _____
Offered with Plans: _____
Mental and Nervous Conditions/Substance Abuse: ____
Offered with Plans: _____

(4) Do the participation requirements comply with applicable statutes and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
_____ Yes _____ No
If No, has the Board approved the carrier's use of an alternate participation requirement?
_____ Yes _____ No

(5) Indicate how coverage for autologous bone marrow transplants is offered.
_____ Plan benefit; or
_____ Rider benefit

HMO/POS Contracts:

(1) List the copayment options being offered.
___$5 Copay ___$10 Copay ___$15 Copay ___$20 Copay

(2) How is the in-plan prescription drug coverage being offered?
$5 Copay Non-network coinsurance level
$10 Copay Non-network coinsurance level
$15 Copay Non-network coinsurance level
$20 Copay Non-network coinsurance level

(3) Do the participation requirements comply with applicable statutes and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
_____ Yes _____ No
If No, has the Board approved the carrier's use of an alternate participation requirement?
_____ Yes _____ No

(4) Indicate how coverage for autologous bone marrow transplants is offered.
_____ Plan benefit; or
_____ Rider benefit

(c) Additional Forms
(1) Is the Preexisting Condition Statement, Exhibit S, being used?
_____ Yes _____ No

(d) Additional Options
(1) Is payment by automatic bank withdrawal required?
_____ Yes _____ No
(2) Is payment by automatic bank withdrawal offered?
(Note: If offered, must be offered on all plans to all small employers.)
_____ Yes _____ No

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. I certify that any stop loss or excess risk insurance issued or renewed by the carrier meets the retention limits set forth in the definition of "stop loss" or "excess risk insurance" as defined at N.J.S.A. 17B:27A–17, as amended by P.L. 1995, c.298.

_____ _____
Date Signature (No stamps)

_____
Title

PART 2
CERTIFICATION OF PROMOTIONAL AND MARKETING MATERIAL

Submit this form pursuant to N.J.A.C. 11:21-17.3 by March 1 of every year to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and to the Division of Life and Health Actuarial Services, New Jersey Department of Banking and Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625-0325, Attn: SEH Promotional and Marketing Certification.

Carrier's Name: _____ NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____

_____
Respondent's Phone: _____ FAX: _____

I, the undersigned, hereby certify that the promotional and marketing material to be disseminated regarding all the standard small employer health benefits plans, including all terms definitions and text, are consistent with N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21.

I 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 (No stamps)

_____
Title

PART 3
CERTIFICATION OF PRIOR FILING AND COMPLIANCE WITH P.L. 1994, C.11

In accordance with N.J.A.C. 11:21-11.8(a), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN-325, Trenton, NJ 08625-0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
Carrier's Name: _____
NAIC # : _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
_____

Respondent's Phone: _____ FAX: _____

2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION (Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)
   a. Form identification number: _____
   b. Form's market name: _____
   c. Date filed (approved) by the Commissioner: _____
   d. Specify which of the following have been approved with respect to this form, providing the most recent date that an approval was received for each:
      Form amendment: _____
      Rider form: _____
      Endorsement form: _____
   e. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?
      ____ Yes ____ No
      If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:
      _____
      _____
      _____
      ____ Check here if additional pages are attached.
   f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?
      ____ Yes ____ No ____ NA
   g. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by which this nonstandard health benefits plan is sold or marketed?
      ____ Yes ____ No ____ NA
      If no, does the carrier market and sell the nonstandard health benefits plan through:
      Agent force: ____ Yes ____ No
      Direct sale: ____ Yes ____ No
   h. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):

January:	_____	July:	_____
February:	_____	August:	_____
March:	_____	September:	_____
April:	_____	October:	_____
May:	_____	November:	_____
June:	_____	December:	_____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, and rules and promulgated thereunder, specifically N.J.A.C. 11:21-3A.
4. CERTIFICATION
   I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
   I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
   I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.
   I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefit plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____
Date Signature

_____
Title

PART 4

CERTIFICATION OF INFORMATIONAL FILING AND COMPLIANCE WITH P.L. 1994, C.11

In accordance with N.J.A.C. 11:21-11.8(b), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN-325, Trenton, NJ 08625-0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
   Carrier's Name: _____

NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
_____
Respondent's Phone: _____ FAX: _____

2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION
(Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)

a. Form identification number: _____

b. Form's market name: _____

c. Specify the reason(s) why this nonstandard health benefits plan was not submitted to the Department for filing prior to April 4, 1994:

_____
_____
_____
____ Check here if additional pages are attached.

d. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No
If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:

_____
_____
_____
____ Check here if additional pages are attached.

e. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No ____ NA
If yes, specify the final date that policies, contracts or certificates will be issued under this nonstandard health benefits plan: ____

f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by which this nonstandard health benefits plan is sold and marketed?
____ Yes ____ No ____ NA
If no, does the carrier market and sell the nonstandard health benefits plan through:
Agent force: ____ Yes ____ No
Direct sale: ____ Yes ____ No

g. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):

January: _____	July: _____
February: _____	August: _____
March: _____	September: _____
April: _____	October: _____
May: _____	November: _____
June: _____	December: _____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, and rules promulgated thereunder.

4. CERTIFICATION
I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefits plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____
Date Signature

_____
Title

PART 5
STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
CHECKLIST AND CERTIFICATION
NONSTANDARD SMALL EMPLOYER HEALTH BENEFIT PLANS AND/OR AMENDMENTS FILED PURSUANT TO N.J.S.A. 17B:27A-19j(6)(b), (6)(c), (11) and (12)

CARRIER: _____
NAIC NO. (If Applicable): _____
IDENTIFYING FORM NUMBERS (List all forms to which this checklist and certification applies and identify for each form whether it is open or closed):
TYPES OF FORMS SUBMITTED:

_____ POLICY/CONTRACT
_____ POLICY/CONTRACT INSERT PAGES/BENEFIT RIDER
_____ CERTIFICATE/EVIDENCE OF COVERAGE
_____ CERTIFICATE/EVIDENCE OF COVERAGE
INSERT PAGES/BENEFIT RIDER
_____ GROUP APPLICATION
_____ EMPLOYEE ENROLLMENT FORM (APPLICATION)

Note: When submitting insert pages or a benefit rider for use with a policy or certificate, the Checklist and Certification should be completed considering the policy or certificate with the insert pages or benefit rider attached. When multiple policy and/or certificate insert pages or policy and/or certificate benefit riders are included in the same submission, to the extent that the insert pages/benefit riders can simultaneously be attached to the policy or certificate, only one Checklist and Certification need be completed for the combination.

1. Do you certify that the form(s) does not include provisions, statements, or questions that pertain to race, creed, color, national origin, ancestry or sexual orientation?
_____ Yes _____ No

2. Is the form(s) in a final printed format?
_____ Yes _____ No

3. Does the form(s) contain a unique identifying number in the lower left-hand corner of the first page?
_____ Yes _____ No

4. Do you certify that the form(s) does not contain any provision or benefit previously disapproved by this Department?
_____ Yes _____ No
If "No", please identify the provision or benefit and when such was disapproved by the Department.
_____
_____

5. Does the form(s) satisfy all of the readability requirements specified in N.J.S.A. 17B:17-21a?
_____ Yes _____ No

6. Do you certify that the form(s) comply with each of the following? If "No" for any response, identify the form number.
   a. N.J.S.A. 17B:27A-18 (applicability of act, availability of coverage)
   _____ Yes _____ No Form # _____
   b. N.J.S.A. 17B:27A-19(b) (guarantee issue)
   _____ Yes _____ No Form # _____
   c. N.J.S.A. 17B:27A-22 (preexisting condition)
   _____ Yes _____ No Form # _____
   d. N.J.S.A. 17B:27A-23 (renewal)
   _____ Yes _____ No Form # _____
   e. N.J.S.A. 17B:27A-24 (participation and contribution requirements)
   _____ Yes _____ No Form # _____
   f. N.J.S.A. 17B:27A-25 (rating)
   _____ Yes _____ No Form # _____
   g. N.J.S.A. 17B:27A-27 (continuation of coverage)
   _____ Yes _____ No Form # _____

7. If a group application, does the form contain the exact statement regarding fraud contained in Section 6c of P.L. 1995, c.132?
_____ Yes _____ No

8. Does the form(s) comply with:
   a. N.J.A.C. 11:4-42.5(a) Domestic Violence?
   _____ Yes _____ No
   b. N.J.A.C. 11:2-13 Group Coverage Discontinuance and Replacement?
   _____ Yes _____ No

c. N.J.A.C. 11:4-28 Group Coordination of Benefits?
_____ Yes _____ No

9. Does the plan contain definitions of the following terms at least as favorable to consumers as those contained in Plan A for the following? See appendix to N.J.A.C. 11:21 for text of Plan A.

a.	Ambulatory Surgical Center	_____ Yes	_____ No
b.	Birthing Center	_____ Yes	_____ No
c.	Dependent	_____ Yes	_____ No
d.	Employee	_____ Yes	_____ No
e.	Extended Care Center	_____ Yes	_____ No
f.	Full-Time	_____ Yes	_____ No
g.	Hospice	_____ Yes	_____ No
h.	Hospital	_____ Yes	_____ No
i.	Nurse	_____ Yes	_____ No
j.	Practitioner (or similar term)	_____ Yes	_____ No
k.	Reasonable and Customary (not applicable to HMO Plans)	_____ Yes	_____ No
l.	Rehabilitation Center	_____ Yes	_____ No
m.	Special Care Unit	_____ Yes	_____ No
n.	Total Disability or Totally Disabled?	_____ Yes	_____ No

10. Does the plan contain provisions at least as favorable to consumers as the following provisions contained in Plan A?

a.	Incontestability	_____ Yes	_____ No
b.	Payment of Premiums—Grace Period	_____ Yes	_____ No
c.	Participation Requirements	_____ Yes	_____ No
d.	Termination of the Policy—Renewal Privilege	_____ Yes	_____ No

11. Does the plan cover at least each of the following charges/services which are covered by Plan A?

a. Charges while hospitalized, 30 days/calendar year (room, board) and ancillary charges.
_____ Yes _____ No

b. Testing—X-Ray and laboratory prior to hospital admission.
_____ Yes _____ No

c. At least 60 days of extended care or rehabilitation (in lieu of hospital confinement, 2 for 1 exchange with hospital days).
_____ Yes _____ No

d. At least 60 days of home health care (2 for 1 exchange with hospital days).
_____ Yes _____ No

e. At least 60 days of hospice care (2 for 1 exchange with hospital days).
_____ Yes _____ No

f. Practitioner charges, nonsurgical while hospitalized
_____ Yes _____ No

Surgical	_____ Yes	_____ No
Anesthesia	_____ Yes	_____ No

g.	Second Opinion	_____ Yes	_____ No
h.	Ambulatory Surgery	_____ Yes	_____ No
i.	Pregnancy coverage on same basis as sickness (No dollar or day limits)	_____ Yes	_____ No
j.	Birthing Center	_____ Yes	_____ No
k.	Newborn Child Coverage	_____ Yes	_____ No
l.	Therapy:		
	Chemotherapy (inpatient and outpatient)	_____ Yes	_____ No
	Radiation (inpatient and outpatient)	_____ Yes	_____ No
	Chelation (inpatient)	_____ Yes	_____ No
	Respiration (inpatient)	_____ Yes	_____ No
	Cognitive rehabilitation and speech (inpatient, aggregate of at least 30/year)	_____ Yes	_____ No
	Occupational and speech (inpatient, aggregate of at least 30/year)	_____ Yes	_____ No
	Infusion (inpatient)	_____ Yes	_____ No

m. Fertility (inpatient, artificial insemination and standard doses, length of treatment and cycles of FDA approved drugs)

EXHIBIT HH

[Carrier] **HMO - POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
POINT OF SERVICE CONTRACT

CONTRACTHOLDER: [ABC Company]

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

EFFECTIVE DATE OF CONTRACT: [January 1, 1998]

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

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

AFFILIATED COMPANIES: [DEF Company]

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies and pay benefits in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its **General Provisions.**

[Secretary President]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

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

Covered Employee Only ..... $]

[Covered Employee and Spouse ..... $

Covered Employee and Child(ren)..... $

Covered Employee and Family ..... $
(including Covered Employee, spouse and one or more eligible dependents)]

We have the right to change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled **General Provisions.**

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

CLASS
[All eligible employees]

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

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

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

MAXIMUM LIFETIME BENEFITS

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

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

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

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Hospital		

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

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

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Mental or Nervous Conditions and Substance Abuse	**Inpatient**: [$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]; Maximum 30 days/ calendar year **Outpatient**: [$15] Copayment / visit; Maximum 20 visits/ calendar year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	Deductible/Coinsurance **Inpatient**: Maximum 30 days/Calendar Year **Outpatient**: Maximum 20 visits/Calendar Year Refer to the Covered Charges with Special Limitations Applicable to [Non-Network] Benefits section for

		an explanation of the rules for exchange
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Prescription Drugs	at the option of the Carrier: [$15] Copayment per prescription; or the [Non-Network] Coinsurance	Deductible/Coinsurance

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

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

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

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

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

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

During a Period of Hospital Confinement
For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, We will cover charges up to the Hospital's average semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the [Member] is being isolated in a private room because the [Member] has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

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

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

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

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

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

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

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

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

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

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

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

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

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

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

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

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

CONTRACTHOLDER. Employer or organization which purchased this Contract.

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

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Contract, as applicable to [Non-Network] benefits. The services and supplies must be:
a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by this Contract. Read the entire Contract to find out what We limit or exclude.

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

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

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

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

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

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

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

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

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

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

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

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

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

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

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

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

DURABLE MEDICAL EQUIPMENT. Equipment We [or the Care Manager] Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a [Member's] home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

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

EMPLOYEE'S ELIGIBILITY DATE.

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

EMPLOYER. [ABC Company].

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

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] Determine are:
a) not of proven benefit for the particular diagnosis or treatment of a [Member's] particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member's] particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.
We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member's] particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a [Member's] particular condition, as explained below.

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

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted

for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
a) The American Medical Association Drug Evaluations;
b) The American Hospital Formulary Service Drug Information; or
c) The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

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

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

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

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

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] Practitioners provide Covered Services and Supplies to [Members].]

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

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

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

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

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

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

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

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

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

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

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

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

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

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

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

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

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in this Contract.

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

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

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

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

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

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

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

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

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

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

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

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

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

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

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

PROVIDER. A recognized Facility or Practitioner of health care.

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

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

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

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

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

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

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

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

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

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

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

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

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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

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

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

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

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

Conditions of Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the

Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.]

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

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

[DEPENDENT COVERAGE

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

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

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

Incapacitated Children
An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a) the child's condition started before he or she reached this Contract's age limit;
b) the child became covered under this Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when the Employee's does.

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

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

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

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible

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

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

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

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

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

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

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

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

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

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

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

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

Newborn Children
We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid][.][and, in order to access [Network] services and supplies, the Employee must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
1) make written request to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

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

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

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

EXTENDED HEALTH BENEFITS

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

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

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

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

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

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

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

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

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

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

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

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

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

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

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

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding position of the [Network] Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the [Member] asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate this Contract in accordance with the General Provisions. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the [Network] Practitioner will cooperate with the [Member] in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A [Member] has the right under New Jersey law to refuse life sustaining treatment. A [Member] who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

a) No [Network] Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any [Network] Provider or other Provider, institution, Facility or agency.

b) Neither the Contractholder nor any [Member] is our agent, representative or employee, or an agent or representative of any [Network] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.

c) [Network] Practitioners maintain the physician-patient relationship with [Members] and are solely responsible to [Members] for all medical services which are rendered by [Network] Practitioners.

d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

[APPEALS PROCEDURE

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

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

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

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

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

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:

- Well child care from birth including immunizations;
- Routine physical examinations, including eye examinations;
- Routine gynecological exams and related services;
- Routine ear and hearing examination; and

Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).

4) **Diagnostic Services.**

5) **Casts and dressings.**

6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Physician and approved in advance by Us.

7) **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in this Contract.

8) **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.

9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.

10) **Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.

[A prescription or refill will not include a prescription or refill that is more than:

a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or

b) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.]

11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance by Us.

12) **Dental x-rays** when related to Covered Services.

13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

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

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]facilities upon prior written authorization by Us); however, [Network] Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and

b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

- As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

⇒ a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and

⇒ a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.

- We provide such coverage subject to the following:

⇒ the attending Practitioner must determine that inpatient care is medically necessary; or

⇒ the mother must request the inpatient care.

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

2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.

3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care

12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

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

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

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

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

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

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center][or Us] [or the Care Manager] prior to seeking emergency treatment.
II. We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior Referral only if:
A. Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
B. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-emergency basis; and
C. We and a [Member's] Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
III. In the event [Members] are hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or [Members] shall be responsible for payment.
5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

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

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

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

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

1. **Skilled nursing services**, provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide**, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a [Member's] medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member's] Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

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

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)**_The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

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

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

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

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that [Member], less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that [Member] is covered by this Contract. And what We pay is based on all the terms of this Contract.

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

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

[Family Deductible Limit
This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Per Covered Family

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

Coinsured Charge Limit
The Coinsured Charge Limit is the amount of Covered Charges a [Member] must incur each Calendar Year before no Coinsurance is required, **except as stated below.**

Exception: Charges for Mental or Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

COVERED CHARGES *APPLICABLE TO [NON-NETWORK] BENEFITS*

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of this Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced or eliminated if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in this Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement.

Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

If a [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. This Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Contract.

Emergency Room Copayment Requirement
Each time a [Member] uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges
We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the [Member's] health.

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Home Health Care Charges:
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Contract and to the following conditions:

I. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
A. ordered by the [Member's] Practitioner;
B. included in the home health care plan: and
C. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
II. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.
III. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
IV. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
V. We do not pay for:
A. services furnished to family members, other than the patient; or
B. services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

Practitioner's Charges for Non-Surgical Care and Treatment
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

[Carrier] covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured [Member]. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of this Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Contract. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

Alcohol Abuse
We pay benefits for the Covered Charges a [Member] incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy
This Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of this Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But We do not pay for replacements or repairs.

Blood
We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the [Member].

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) any purchases without Our advance written approval;
b) replacements or repairs; or

c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of this Contract.

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices
We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of this Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every 2 years, for a female [Member], ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female [Member] ages 50 and older.

Private Duty Nursing Care
We only cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

We cover the following Therapy Services:
Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

We cover the Therapy Services listed below, subject to stated limitations:

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

Preventive Care
We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography , screening tests and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:
a) $500 per [Member] for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per [Member] for all other [Member]s.

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Immunizations and Lead Screening
We will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Vision Screening
We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Mental or Nervous Conditions and Substance Abuse
We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A [Member] may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The [Member] must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit coverage for all treatment of Mental or Nervous Conditions and Substance Abuse per Calendar Year to:
a) thirty (30) days of Inpatient confinement; and

b) twenty (20) Outpatient visits.
One or more of any unused Inpatient days may be exchanged on a two-for-one-basis for additional Outpatient visits.

We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich
- Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which We do not Pre-Approve are not covered.]**

[h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a [Member].

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery,** except as otherwise stated in this Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract.

Care or treatment by means of **dose intensive chemotherapy,** except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the [Member] with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following [members] of the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine**.

Services or supplies related to **Hypnotism**.

Services or supplies necessary because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment**, except as otherwise stated in the Preventive Care section of this Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or-who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** except as specified in this Contract.

With respect to [Non-Network] benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of this Contract.

Services or supplies that are not furnished by an eligible **Provider.**

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to [Network] services and supplies provided in the event of a Medical Emergency, and with respect to all [Non-Network] benefits.

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of this Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or

- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and
- Subject to Our Pre-Approval, full-time student status, provided the [Member] is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker**, except as otherwise stated in this Contract.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member's] sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

[IMPORTANT NOTICE *APPLICABLE ONLY TO [NON-NETWORK] BENEFITS*

[This Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a [Member]:

a) is admitted as an Inpatient to a Hospital, or

b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under this Contract. See the **Utilization Review Features** section for details.]

[This Contract has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a [Member's] medical needs in clinical situations with the potential for catastrophic claims to Determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[This Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of this Contract. Read this Contract carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Contract he or she should [call The Group Claim Office at the number shown on his or her Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with this Contract's utilization review features, he or she will not be eligible for full benefits under this Contract.

Compliance with this Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under this Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Contract.

Definitions

"Hospital admission" means admission of a [Member] to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the [Member's] condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the [Member's] life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Contract is not payable under this Contract.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a [Member] is not satisfied with a utilization review decision, the [Member] or the [Member's] Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review Practitioner. This Practitioner will discuss the case with the Practitioner reviewer who made the initial decision. The second medical review Practitioner will then discuss the case with the [Member's] Practitioner. The [Member's] Practitioner is then notified of the appeal's recommendation and referred to Us for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Contract.

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The [Member] or the [Member's] Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a [Member] or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC]notifies the [Member's] Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all emergency admission by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review
The [Member] or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The [Member], or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the [Member's] Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, by **50%**] if:
a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges **by 50%**], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet this Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Contract.

We require a [Member] to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The [Member] or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] must obtain a second surgical opinion in order to get full benefits under this Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the [Member]. The Practitioner he or she chooses fills them out. and then returns them to [ABC].

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[ALTERNATE TREATMENT FEATURES

Important Notice: No [Member] is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are Determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a [Member] in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under this Contract.

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury Determined by [DEF] or Us to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the [Member], [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the [Member], or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Contract.

The agreed upon alternate treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion
Alternate Treatment does not include services and supplies that We [or the Care Manager] Determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to Determine whether the [Member] is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be considered as Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the [Member].

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Contract. However, the Utilization Review Features will not apply.]]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS
"Plan" means any of the following that provide health expense benefits or services:

a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. For a Member or Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works
We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information
In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver
We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means that of service or expense provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services and Benefits this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide services and benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

Medicare

If the [Non-Network] benefits under this Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AFFILIATED COMPANIES

If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

An Employee of the Contractholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Contract. That Employee's service with multiple Employers will be treated as service with that one.

The Contractholder must notify Us in writing when a company stops being an Affiliated Company. As of this date, this Contract will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Contractholder or another Affiliated Company as eligible Employees.

AMENDMENT

The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a) it is shown in an endorsement on it signed by one of Our officers.

b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.

c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.

d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Contractholder or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS

No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under this Contract will reduce a [Member's] Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, [or the amount of coverage], subject to this Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Contract, [and in what amounts].

CONFORMITY WITH LAW

Any provision of this Contract which, on its Effective Date, is in conflict with the laws of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONTRACT INTERPRETATION

We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

In the event this Contract is amended, and such amendment affects the material contained in the evidence of coverage, a rider or revised evidence of coverage reflecting such amendment will be issued to the Contractholder for delivery to affected Employees.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a [Member]: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET
We reserve the right, before paying [Non-Network] benefits to a [Member], to use the amount of payment due to offset a [Non-Network] claims payment previously made in error.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

[Network] Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates, or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an eligible Employee is not covered by this Contract because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Contractholder,

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

PREMIUM AMOUNTS
The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage provided under this Contract. Those charges are Determined from the Premium rates then in effect and the Employees and Dependents then covered.

Premium payments may be Determined in another way. But it must produce the same amounts and be agreed to by the Contractholder and Us.

The following will apply if one or more Premiums paid include Premium charges for a [Member] whose coverage has ended before the due date of that Premium. We will not have to refund more than [the amount of (a) minus (b):

a) the amounts of the Premium charges for the [Member] that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contractholder that the [Member's] coverage has ended.
the amount of any claims paid or the value of any services provided to [Members] after their coverage has ended.]

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge Determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the **Schedule of Premium Rates and Classification** section of the Contract. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) any date that the extent or nature of the risk under the Contract is changed:
- by amendment of the Contract; or
- by reason of any provision of law or any government program or regulation;

d) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to Determine the premium rates and certify status as a Small Employer. All records of the Contractholder and of the Employer which bear on this Contract must be open to Us for Our inspection at any reasonable time.

We will not have to perform any duty that depends on such data before it is received in a form that satisfies Us. The Contractholder may correct incorrect data given to Us, if We have not been harmed by acting on it. A person's coverage under this Contract will not be made invalid by failure of the Contractholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Contractholder will furnish Us the Employee [and Dependents] eligibility requirements of this Contract that apply on the Effective Date. Subject to Our approval, those requirements will apply to the Employee [and Dependent] coverage under this Contract. The Contractholder will notify Us of any change in the eligibility requirements of this Contract, but no such change will apply to the Employee [or Dependent] coverage under this Contract unless approved in advance by Us.

The Contractholder will notify Us of any event, including a change in eligibility, that causes termination of a [Member's] coverage immediately, or in no event later than the last day of the month in which the event occurs. Our liability to arrange or provide benefits for a person ceases when the person's coverage ends under this Contract. [If the Contractholder fails to notify Us as provided above, We will be entitled to reimbursement from the Contractholder of any benefits paid to any person after the person's coverage should have ended.]

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE
We have the right to non-renew this Contract on any premium due date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves its principal place of business outside the State of New Jersey;
b) subject to the statutory notification requirements, We cease to do business in the small group market;
c) subject to the statutory notification requirements, [Carrier] ceases offering and non-renews a particular type of Health Benefits Plan in the small group market;
d) less than [75%] of the eligible Employees are covered by this Contract. If an eligible Employee is not covered by this Contract because:
- the Employee is covered as a Dependent under a spouse's coverage; or
- the Employee is covered under an alternate Health Benefits Plan offered by the Contractholder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e) the Contractholder does not contribute at least 10% of the annual cost of the Contract; [or]
f) the Contractholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member][;][.]
g) [there is no eligible Employee who resides, lives, or works in Our approved Service Area, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member.]; or
h) the Small Employer no longer has any enrollee in connection with this Contract who lives, resides, or works in Our Service Area and We would deny enrollment with respect to such Contract, as permitted by law.]

We have the right to non-renew this Contract on any premium due date subject to 30 days advance written notice to the Contractholder for the following reason:

During or at End of Grace Period- Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. But the Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested.

Immediate cancellation will occur if the Contractholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Contract. This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of coverage hereunder will begin and end at 12:01 a.m. Eastern Standard Time at the Contractholder's place of business.

The Contractholder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on the Contract Anniversary following the date the Contractholder no longer meets the requirements of a Small Employer as defined in this Contract.

The Contractholder must certify to Us the it's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Contractholder fails to do this, We retain the right to take the actions described above as of the Contractholder's Contract Anniversary.

THE CONTRACT
The entire Contract consists of:
[a) the forms shown in the Table of Contents as of the Effective Date;
b)] the Contractholder's application, a copy of which is attached to the Contract;
[c)] any riders, [endorsements] or amendments to the Contract; and
[d)] the individual applications, if any, of all [Members].

Information in a Contractholder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to the Contractholder for attachment to this Contract.

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a [Member], and We furnish a copy to the [Member] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION
The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

A claimant's right to make a claim for any benefits provided by this Contract is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 day of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;

c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Contract to such provider.

PHYSICAL EXAMS
We, at Our expense have the right to examine the [Member]. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)**: If a [Member] is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a [Member] elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to the Employee.

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:
a) he or she was not terminated due to gross misconduct; and
b) he or she is not entitled to Medicare.

The continuation:
a) may cover the Employee and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:

a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits; the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:

I. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
II. with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
A. the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
B. the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
III. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
IV. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
V. the date this Contract ends;
VI. the end of the period for which the last premium payment is made;
VII. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
VIII. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End
If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then covered Dependents whose coverage would otherwise end at this time. If an Employee acquires one or more Dependents after the continued health coverage begins, he or she may elect to

add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:

a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed covered under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends
A [Member's] continued health coverage end on the first of the following;

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the [Member];
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the [Member], the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [• if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.
"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered person received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE AS SECONDARY PAYOR (Continued)
MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a [Member] who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

MEDICARE AS SECONDARY PAYOR (Continued)
MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and

b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.].

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.
c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.200, effective April 15, 1996.
See: 28 N.J.R. 27(a), 28 N.J.R. 2042(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).

EXHIBIT II

[INTRODUCTION]

What is a Point of Service Plan?
A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of ***in-network providers*** as well as the services of ***out-of-network providers***. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician) or those of an ***out-of-network provider***.

What is the difference between an in-network provider and an out-of-network provider?
An ***in-network provider*** is a doctor, other practitioner or facility that has an agreement with [Carrier] to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. An ***out-of-network provider*** is any licensed or certified provider that does not have a specific agreement with [Carrier].

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of an ***in-network provider*** rather than the services of an ***out-of network provider***.

How does the POS plan describe in-network and out-of-network coverage?
The POS plan contains a section which describes in-network coverage and sections which describe out-of-network coverage. The POS plan also contains many sections which apply to both the use of the services of ***in-network providers*** or the services of ***out-of-network providers***.

- **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment for use of an ***in-network provider*** as well as the deductible and coinsurance requirement for the use of an ***out-of-network provider***. The **SCHEDULE** also identifies some limitations to coverage.

- **COVERED SERVICES AND SUPPLIES.** This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of an ***in-network provider***.

- **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if her or she were to use the services of an ***out-of-network provider***.

How does a person access in-network providers?
[Carrier] will provide a [directory] listing all the Primary Care Physicians and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Physician, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying [Carrier].

Except in case of a medical emergency, in-network services and supplies can **only** be provided by an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician). [While certain routine OB/GYN care may be secured without going through the PCP, all other in-network services and supplies require the authorization of the PCP.]

How much will it cost for services and supplies if a person uses in-network providers?
[The Identification Card will specify the amount of the copayment the ***in-network provider*** will collect for most services and supplies.] For many services, after a person pays a copayment for the PCP visit, further services and supplies require no additional payment. Home Health Care and Durable Medical Equipment are examples of such services and supplies. [Carrier elected to cover prescription drugs subject to the same coinsurance requirement as applies to out-of-network covered charges.][Carrier elected to cover prescription drugs subject to a $[15] copayment.]

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of an out-of-network provider?
Persons covered under a POS plan may use the services of an out-of-network provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from [Carrier], as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses out-of-network providers?
After the payment of the applicable calendar year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit is the first out-of network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, [Carrier] would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a calendar year, further charges are only subject to the applicable coinsurance. **Note:** [Carrier] pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Reasonable and Customary Charge, as defined in the Contract and the Evidence of coverage.

Does the POS plan cover the same services and supplies whether a person uses in-network providers or out-of-network providers?
The POS plan was designed to include the same services and supplies whether the person uses ***in-network*** or ***out-of-network providers***. However, the **extent** of coverage differs for some services and supplies. For example, if a person elects to use an ***in-network provider*** for extended care services (skilled nursing care), coverage is unlimited as to number of days. If a person uses an ***out-of-network provider***, extended care services are limited to 120 days.

Since in-network services and supplies must be coordinated by a PCP, and ***in-network providers*** are familiar with in-network covered services and supplies, the list of in-network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of network covered charges. In addition, [Carrier] is able to offer more details as to the nature and extent of the in-network coverage.

For services and supplies that are subject to limitations, can a person receive both in-network and out-of-network services and supplies?
The POS plan allows a person to receive any combination of in-network and out-of network services and supplies. However, for services and supplies subject to limitations, the POS plan includes offset provisions to coordinate the **total** services and supplies a person may receive.

PLEASE REFER TO THE CONTRACT [AND EVIDENCE OF COVERAGE] FOR COMPLETE INFORMATION CONCERNING THE POS PLAN AND USE OF IN-NETWORK AND OUT-OF-NETWORK PROVIDERS.

[Carrier] **HMO - POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
POINT OF SERVICE EVIDENCE OF COVERAGE

[Carrier] certifies that the Employee named below is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

CONTRACTHOLDER:	[ABC Company]
GROUP CONTRACT NUMBER	[G-12345]
[EMPLOYEE	John Doe]
EVIDENCE OF COVERAGE NUMBER	C-123456]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE:	[July 1, 1997]
SERVICE AREA	[State of New Jersey]
AFFILIATED COMPANIES:	[DEF Company]

[COST OF COVERAGE
The coverage described in this Evidence of Coverage is Contributory Coverage. You will be advised of the amount of Your contribution when You enroll.]

[Carrier's address
100 Main Street, Any Town, NJ 00000-0000]

HMO/POS-EOC

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SCHEDULE OF CLASSIFICATION

The Contract's classification, and the coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

[NON-NETWORK]	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500, or $1000]
Per Covered Family	[$500, $1,000 or $2,000 NOTE: Must be individually satisfied by 2 separate Covered Persons] [$750, $1500, or $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] [**except as stated below**]
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	25%]
Coinsured Charge Limit	$10,000
[NETWORK]	Unlimited, **except** as otherwise stated
[NON-NETWORK]	$5,000,000 per [Member], **except** as otherwise stated

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THE CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Hospital		
Inpatient (unlimited days)	[$150] Copayment / day; maximum / admission [$750]; maximum / cal.	Deductible/Coinsurance

	year [$1500]	
Outpatient Visit	[$15] Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	$50 Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	$50 Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Maternity	$25 Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment / visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$15] Copayment / visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Mental or Nervous Conditions and Substance Abuse	**Inpatient:** [$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]; Maximum 30 days/ calendar year **Outpatient:** [$15] Copayment / visit; Maximum 20 visits/ calendar year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	Deductible/Coinsurance **Inpatient:** Maximum 30 days/Calendar Year **Outpatient:** Maximum 20 visits/Calendar Year Refer to the Covered Charges with Special Limitations Applicable to [Non-Network] Benefits section for an explanation of the rules for exchange

Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Prescription Drugs	at the option of the Carrier: [$15] Copayment per prescription; or the [Non-Network] Coinsurance	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Home Health Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Podiatric Care	[$15] Copayment / visit	Deductible/Coinsurance

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER][OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

During a Period of Hospital Confinement
For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, We will cover charges up to the Hospital's average semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the [Member] is being isolated in a private room because the [Member] has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

For Special Care Units, We will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contractholder through common ownership of stock or assets.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a Member. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. *NOTE: The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to [Non-Network] benefits. The services and supplies must be:

a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by the Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CUSTODIAL CARE. Any service or supply, including room and board, which:

a) is furnished mainly to help a [Member] meet a [Member's] routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT. Your:

a) legal spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of the Contract.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by the Contract as an Employee.

At Our Discretion, We can require proof that a person meets the definition of a Dependent.]

[DEPENDENT'S ELIGIBILITY DATE.

The later of:

a) Your Eligibility Date; or
b) the date the person first becomes a Dependent.]

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and

c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We [or the Care Manager] Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a [Member's] home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Contract for a Member.

EMPLOYEE. A Full-Time paid Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] Determine are:
a) not of proven benefit for the particular diagnosis or treatment of a [Member's] particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member's] particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member's] particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a [Member's] particular condition, as explained below.

We [or the Care Manager] will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
a) The American Medical Association Drug Evaluations;
b) The American Hospital Formulary Service Drug Information; or
c) The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

FACILITY. A place which:
a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Contract.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] Practitioners provide Covered Services and Supplies to [Members].]

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a [Member].

[INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.]

INJURY. Damage to a [Member's] body, and all complications arising from that damage.

INPATIENT. [Member], if physically confined as a registered bed patient in a Hospital or other health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under the Contract more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage [and Dependent Coverage] subsection[s] of the **Eligibility** section of the Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include but are not limited to heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER]. An eligible person who is covered under the Contract [(]includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or

c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental or Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-COVERED CHARGES. Charges which do not meet the Contract's definition of Covered Charges or which exceed any of the benefit limits shown in the Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by the Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in the Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Contract.

OUTPATIENT. Member, if not confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We [or the Care Manager] Determine if the cause(s) of the confinements are the same or related.

PER LIFETIME. During the lifetime of an individual, regardless of whether he or she was covered under the Contract or any other contract, policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption of coverage.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Contract.

PRE-APPROVAL or PRE-APPROVED. Our written approval for specified services and supplies prior to the date the charges are incurred. Services or supplies for which the charges have not been pre-approved are not covered.

[**PRE-EXISTING CONDITION LIMITATION.** With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of the Contract for details on how the Contract limits the services and benefits for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:

a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;

b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to [Network] services and supplies, the negotiated arrangement. With respect to [Non-Network] benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the [Non-Network] benefits under the Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the Care Manager] in conformance with Our policies and procedures that directs a [Member] to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

SPECIAL CARE UNIT. A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:
a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.
a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as surgery.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in the Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

[**WAITING PERIOD.** With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.]

[**WE, US, OUR.** [Carrier].

YOU, YOUR, AND YOURS. The Employee.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] will be eligible if the Employees are [Actively at Work] Full-Time Employees. [In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

For purposes of the Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status Related Factor, and except as stated below,]We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

Enrollment Requirement
We will not cover You until the You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee's Eligibility Date, coverage will start on Your Employee's Eligibility Date.

If You enroll and agree to make the required payments, if any:
a) more than [30] days after Your Employee's Eligibility Date; or
b) after You previously had coverage which ended because You failed to make a required payment;
We will consider You to be a Late Enrollee. Late Enrollees are subject to the Contract's Pre-Existing Conditions limitation.

When You initially waive coverage under the Contract, the Plan Sponsor [or We] should notify You of the requirement for the Employee to make a statement that waiver was because You were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If You initially waived coverage under the Contract and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under the Contract, We will not consider You [and Your Dependents] to be [a] Late Enrollee[s], provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation;
e) death of Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll under the Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under this Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

[The Waiting Period
The Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Employer.]

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier. You may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Contract's eligibility waiting period if:
a) You were employed by the Employer on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Multiple Employment
If You work for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Contract. But, if the Contract uses the amount of an Employee's earnings to determine class, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status Related Factor, and except as stated below,]You must be [Actively at Work, and] working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. [If You are not Actively at Work on the scheduled Effective Date and do not qualify for the exception to the Actively at Work requirement, We will postpone the start of Your coverage until You return to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.]

You must elect to enroll and agree to make the required payments if any, within [30] days of Your Employee's Eligibility Date. If You do this within [30] days of Your Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of Your coverage.

If You do this more than [30] days after Your Employee's Eligibility Date, We will consider You a Late Enrollee. Coverage is scheduled to start on the date You sign the enrollment form.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Contractholder who purchased the replacement Contract purchased it to replace a plan the Contractholder had with some other carrier. If You are not Actively at Work due to Total Disability on the date the replacement Contract takes effect You will initially be eligible for limited coverage under the replacement Contract if:
a) You were validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the replacement Contract takes effect immediately upon termination of the prior plan.

The coverage under the replacement Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the replacement Contract will end one year from the date the person's coverage under the replacement Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the replacement Contract.]

When Employee Coverage Ends
Your coverage under the Contract will end on the first of the following dates:
a) [the date] You cease to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] You stop being an eligible Employee under the Contract.
c) the date the Contract ends,[or is discontinued for a class of Employees to which You belong.]

d) the last day of the period for which required payments have been made for You, subject to the **Payment of Premium - Grace Period** section.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. The Contract's benefits provisions explain these situations. Read the Contract's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are:
a) Your legal spouse;
b) Your unmarried Dependent children who are under age 19; and
c) Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Eligible Dependents will not include any Dependent who is:
a) covered by the Contract as an Employee or
b) on active duty in the armed forces of any country.

Adopted Children and Step-Children
Your "unmarried Dependent children" include Your legally adopted children, Your step-children if they depend on You for most of their support and maintenance and children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past the Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a) the child's condition started before he or she reached the Contract's age limit;
b) the child became covered under the Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Contract. We consider an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent [and agree to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Contract's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When You initially waive coverage for a spouse and/or eligible Dependent children under the Contract, the Plan Sponsor [or We] should notify You of the requirement for You to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If You previously waived coverage for Your spouse or eligible Dependent children under the Contract and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation;
e) death of the Your spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, We will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Contract, to be a Late Enrollee, if:
a) You are under legal obligation to provide coverage due to a court order; and
b) You enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

In addition, if an Employee initially waived coverage under this Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for Your Dependent coverage to begin, You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Contract, the date Your Dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date You become covered for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date You sign the enrollment form; or
b) the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child or newly adopted child will be covered from the later of:
a) the date You notify Us [and agree to make any additional payments], or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Contractholder who purchased the replacement Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date the replacement Contract takes effect will initially be eligible for limited coverage under the replacement Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the replacement Contract takes effect immediately upon termination of the prior plan.

The coverage under the replacement Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the replacement Contract will end one year from the date the person's coverage under the replacement Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the replacement Contract.

Newborn Children
We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:
a) If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid][.][and, in order to access [Network] services and supplies, You must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If You are not covered for Dependent child coverage on the date the child is born, You must:
1) make written request to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the request is not made [and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's coverage under the Contract will end on the first of the following dates:
a) [the date] Your coverage ends;

[b) the date You stop being a member of a class of Employees eligible for such coverage;]
[c)]. the date the Contract ends;
[d)]. the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
[e). the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.]
[f)]. At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read the Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If the Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the Member.

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies, or charges incurred by other family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

You must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Contract:
a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the Member.
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In a Medical Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the Member.]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The [Member] can select another Primary Care Physician from Our [Physician or Practitioners Directory].

[Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If We receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to the Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under the Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If You are the [Member] who misuses the card, coverage may be terminated for You as well as any of Your Dependents who are [Members]. To be eligible for services or benefits under the Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under the Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of the Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to the Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under the Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under the Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

REFERRAL FORMS
A [Member] can be referred for Specialist Services by a [Member's] Primary Care Physician.

Except in the case of a Medical Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Physician (including but not limited to Specialist Services) if a [Member] has not been referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding position of the [Network] Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the [Member] asks, in writing and within 7 days of being informed of the result of

the Appeals Procedure, to terminate this Contract in accordance with the General Provisions. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the [Network] Practitioner will cooperate with the [Member] in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A [Member] has the right under New Jersey law to refuse life sustaining treatment. A [Member] who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a Member, such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under the Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

a) No [Network] Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any [Network] Provider or other Provider, institution, Facility or agency.

b) Neither the Contractholder nor any [Member] is our agent, representative or employee, or an agent or representative of any [Network] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under the Contract.

c) [Network] Practitioners maintain the physician-patient relationship with [Members] and are solely responsible to [Members] for all medical services which are rendered by [Network] Practitioners.

d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

COVERED SERVICES AND SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [or Coinsurance] as stated in the applicable Schedule.

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

I. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
II. **Home visits** by a [Member's] Primary Care Physician.
III. **Periodic health examinations** to include:
A. Well child care from birth including immunizations;
B. Routine physical examinations, including eye examinations;
C. Routine gynecological exams and related services;
D. Routine ear and hearing examination; and
Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).
IV. **Diagnostic Services.**
V. **Casts and dressings.**
VI. **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Physician and approved in advance by Us.
VII. **Procedures and prescription drugs to enhance fertility**, except where specifically excluded in the Contract.
VIII. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
IX. **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.
X. **Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.
A prescription or refill will not include a prescription or refill that is more than:

a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.

11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance by Us.

12) **Dental x-rays** when related to Covered Services.

13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]facilities upon prior written authorization by Us); however, [Network] Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

1. Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.
• As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
⇒ a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.
• We provide such coverage subject to the following:
⇒ the attending Practitioner must determine that inpatient care is medically necessary; or
⇒ the mother must request the inpatient care.
• [As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.
20.
21. Private duty nursing only when approved in advance by Us.
22. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
23. Allogeneic bone marrow transplants.
[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]
[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS.** The following Services are covered when rendered by a [Network] Provider at Provider's office or at a [Network] Substance Abuse Center [or Health Center] [upon prior Referral by a [Member's] Primary Care Physician] [or the Care Manager].

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member's] Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member's] Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** [Members] are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate, and only to the extent of the covered benefit as defined above.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS BENEFITS A [MEMBER] RECEIVES AS [NON-NETWORK] BENEFITS WILL REDUCE THE BENEFITS AVAILABLE AS [NETWORK] MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Physician in the event of a Medical Emergency as Determined by Us.

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center][or Us] [or the Care Manager] prior to seeking emergency treatment.

II. We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior Referral only if:

A. Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.

B. The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-emergency basis; and

C. We and a [Member's] Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

III. In the event [Members] are hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of the Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or [Members] shall be responsible for payment.

5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager].

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a [Network] Provider by a [Member's] Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a [Member's] Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a [Member's] condition within this time period and treatment is approved in writing by Us.

2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy and Respiration Therapy.

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.

(g) **HOME HEALTH SERVICES.** The following services are covered when rendered by a [Network] Provider including but not limited to a [Network] Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a [Member's] Primary Care Physician [or the Care Manager].

1. **Skilled nursing services**, provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide**, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a [Member's] medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member's] Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our Determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)**_The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

[NON-NETWORK] BENEFIT PROVISION *APPLICABLE TO [NON-NETWORK] BENEFITS*

The Cash Deductible

Each Calendar Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by the Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that [Member] is covered by the Contract. And what We pay is based on all the terms of the Contract.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:

a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the Calendar Year in which the Contract starts;
b) the charges would have been considered Covered Charges under the Contract if the Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit
The Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any [Member] of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of the Contract.]

[Per Covered Family
The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more [Members] in a family have incurred a combined total of Covered Charges toward their Per Person Cash Deductible equal to the per Covered Family Cash Deductible, each [Member] in that family will be considered to have met his or her Per Person Cash Deductible for the rest of that Calendar Year. The Charges that each [Member] in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Person Cash Deductible.]

Coinsured Charge Limit
The Coinsured Charge Limit is the amount of Covered Charges a [Member] must incur each Calendar Year before no Coinsurance is required, **except as stated below.**

Exception: Charges for Mental or Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

COVERED CHARGES ***APPLICABLE TO [NON-NETWORK] BENEFITS***

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of the Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced or eliminated if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in the Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement.

Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Participating Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

If a [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to the Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. The Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of the Contract.

Emergency Room Copayment Requirement
Each time a [Member] uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges
We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the [Member's] health.

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Home Health Care Charges:
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Contract and to the following conditions:

I. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
A. ordered by the [Member's] Practitioner;
B. included in the home health care plan: and
C. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
II. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.
III. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
IV. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
V. We do not pay for:
A. services furnished to family members, other than the patient; or
B. services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

Practitioner's Charges for Non-Surgical Care and Treatment

We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

We do not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Member. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of the Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Contract. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

Alcohol Abuse
We pay benefits for the Covered Charges a [Member] incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy
The Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But We do not pay for replacements or repairs.

Blood
We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Member.

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) any purchases without Our advance written approval;
b) replacements or repairs; or
c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Member. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of the Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

X-Rays and Laboratory Tests

We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Contract.

COVERED CHARGES WITH SPECIAL LIMITATIONS ***APPLICABLE TO [NON-NETWORK] BENEFITS***

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices
We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of the Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female Member, ages 35 - 39
b) one mammogram, every 2 years, for a female Member, ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female [Member] ages 50 and older.

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

We cover the following Therapy Services:
Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

We cover the Therapy Services listed below, subject to stated limitations:

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

Preventive Care
We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography , screening tests and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:
a) $500 per [Member] for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per [Member] for all other [Members].

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Immunizations and Lead Screening
We will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Vision Screening
We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Mental or Nervous Conditions and Substance Abuse
We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A [Member] may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The [Member] must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit coverage for all treatment of Mental or Nervous Conditions and Substance Abuse per Calendar Year to:
a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.
One or more of any unused Inpatient days may be exchanged on a two-for-one-basis for additional Outpatient visits.

We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas

g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich
- Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which We do not Pre-Approve are not covered.]**

[h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THE CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in the Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in the Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in the Contract.

Services or supplies, the primary purpose of which is **educational** providing the [Member] with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a. except as otherwise stated in the Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in the Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Services or supplies related to **Hypnotism.**

Services or supplies necessary because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment**, except as otherwise stated in the Preventive Care section of the Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Contract. See the Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to Determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We wave this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under the Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on

coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under the Contract starts. If the Employer has included an eligibility waiting period in the Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** except as specified in the Contract.

With respect to [Non-Network] benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of the Contract.

Services or supplies that are not furnished by an eligible **Provider.**

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to [Network] services and supplies provided in the event of a Medical Emergency, and with respect to all [Non-Network] benefits.

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of the Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and
- Subject to Our Pre-Approval, full-time student status, provided the [Member] is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker,** except as otherwise stated in the Contract.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member's] sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

[IMPORTANT NOTICE ***APPLICABLE ONLY TO [NON-NETWORK] BENEFITS***

[The Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a Member:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under the Contract. See the **Utilization Review Features** section for details.]

[The Contract has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a [Member's] medical needs in clinical situations with the potential for catastrophic claims to Determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of the Contract. Read the Contract carefully and keep it available when consulting a Practitioner.

If You have any questions after reading the Contract You should [call The Group Claim Office at the number shown on Your Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with the Contract's utilization review features, he or she will not be eligible for full benefits under the Contract.

Compliance with the Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under the Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Contract.

Definitions
"Hospital admission" means admission of a [Member] to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the [Member's] condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the [Member's] life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Contract is not payable under the Contract.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a [Member] is not satisfied with a utilization review decision, the [Member] or the [Member's] Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review Practitioner. This Practitioner will discuss the case with the Practitioner reviewer who made the initial decision. The second medical review Practitioner will then discuss the case with the [Member's] Practitioner. The [Member's] Practitioner is then notified of the appeal's recommendation and referred to Us for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Contract.

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The [Member] or the [Member's] Practitioner must *notify* [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a [Member] or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all emergency admission by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review
The [Member] or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Member, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the [Member's] Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;

b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, by 50%] if:
a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet the Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Contract.

We require a [Member] to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The [Member] or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] must obtain a second surgical opinion in order to get full benefits under the Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Member. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of the Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[ALTERNATE TREATMENT FEATURES

Important Notice: No [Member] is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a [Member] in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under the Contract.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury Determined by [DEF] or Us to be catastrophic.

Alternate Treatment Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Member, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Member, or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Alternate Treatment Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; Member; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Contract.

The agreed upon alternate treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion
Alternate Treatment does not include services and supplies that We [or the Care Manager] Determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to Determine whether the [Member] is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be considered as Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Member.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Contract. However, the Utilization Review Features will not apply.]]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by the Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:
a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. For a Member or Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification

of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works
We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information
In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver
We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) the Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means that of service or expense provided for treatment of an Injury which is covered under the Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under the Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

If there is a dispute as to which policy is primary, the Contract will pay benefits or provide services as if it were primary.

Services and Benefits the Contract will provide if it is primary to PIP or OSAIC.
If the Contract is primary to PIP or OSAIC it will provide **services and** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.
If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

Medicare
If the [Non-Network] benefits under the Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AMENDMENT
The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under the Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under the Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of the Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT
No assignment or transfer by the Contractholder or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under the Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under the Contract will reduce a [Member's] Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, [or the amount of coverage], subject to the Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Contract, [and in what amounts].

CONFORMITY WITH LAW
Any provision of the Contract which, on its Effective Date, is in conflict with the laws of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under the Contract.

CONTRACT INTERPRETATION
We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under the Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a Member: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET
We reserve the right, before paying [Non-Network] benefits to a Member, to use the amount of payment due to offset a [Non-Network] claims payment previously made in error.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in the Contract, its riders and attachments. We have no other liability.

[Network] Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates, or appropriate employees or companies in administering the Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under the Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a Member, or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

THE CONTRACT
No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the [Member] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION
The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

A claimant's right to make a claim for any benefits provided by the Contract is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 day of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Contract to such provider.

PHYSICAL EXAMS
We, at Our expense have the right to examine the Member. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under the Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of the Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)**: If a [Member] is eligible to continue his or her group health benefits under both the Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of the Contract:

If a [Member] elects to continue his or her group health benefits under both the Contract's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Member:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. You must contact Your Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Contract as:

a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under the Contract during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:
a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:
a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If you die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Contract, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) Your legal divorce or legal separation from Your spouse; or
b) the loss of dependent eligibility, as defined in the Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue the Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:

a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under the Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:

I. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
II. with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
A. the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
B. the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
III. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
IV. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
V. the date the Contract ends;
VI. the end of the period for which the last premium payment is made;
VII. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
VIII. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read the Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End
If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. If You acquire one or more Dependents after the continued health coverage begins, You may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, You must elect to continue health coverage for Yourself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify You, in writing, of:

a) Your right to continue the Contract's group health benefits;
b) the monthly premium You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under the Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage
Your continued coverage will be identical to the coverage You had when covered under the Contract on a regular basis. Any modifications made under the Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for You to continue.

When Continuation Ends
A [Member's] continued health coverage end on the first of the following;

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under the Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if You stop paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Contract ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Contract.

FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. You must contact Your Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to You.

If An Employee's Group Health Coverage Ends
Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date You return to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
If You die, any of Your Dependents who were covered under the Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of Your death; or

b) the date the Dependent is no longer eligible under the terms of the Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for Your former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [•if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under the Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by the Contract.
"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.
"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under the Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered person received from a third

party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to You or Your covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Member, other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When the Contract is primary
When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a [Member] who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek

assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.
c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.199, effective April 15, 1996.
See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).

EXHIBIT JJ

All text which is enclosed in brackets is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in five ways.

Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].

1) Some areas of variability are noted with brief explanations within the text.
2) Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
3) Some areas of variability are subject to ranges specified in statute or regulation.
4) Some areas of variability are determined by Carrier elections. [Examples include the use of a care manager, health center, and terms to identify the member, network and non-network benefits.]

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

1) The forms define and use the terms "Network" or "In-Network" and "Non-Network" or "Out-of-Network." Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms. (Example: Participating, Non-Participating)
2) The forms define and use the term "Member." Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
3) The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
4) Copayment, deductible and coinsurance amounts may be elected by the Contractholder, subject to the availability specified in regulation. (Example: "Non-Network options are consistent with the options set forth in Exhibits C and D of the Appendix to N.J.A.C. 11:21.")
5) The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
6) Carriers that do not use a "Care Manager" should omit the definition of Care Manager, and omit the term as it appears throughout the text.
7) The definition of "Employer" should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
8) Carriers that do not use "Health Care Centers or Health Centers" should omit the definition of Health Care Centers or Health Centers, and omit the terms as they appear throughout the text.
9) The "Waiting Period" provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed six months, as set forth in N.J.A.C. 11:21-7.9(c). (Contract Only). If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
10) The date employee or dependent coverage begins or ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may begin as of the first of the month following any waiting period. Coverage may end immediately, or at the end of the month in which the termination event occurs.)
11) The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration, but may not be more restrictive to the member than stated in the form.
12) Carriers that do not have a home care program that satisfies the requirements of the New Jersey "48 hour maternity" statute, (P.L.1995, c.138) should omit the reference to such program in the text of the Inpatient Hospice, Hospital, Rehabilitation Center & Skilled Nursing benefits section of the plan.
13) Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note*: All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
14) Carriers may elect to calculate the family deductible as two times the individual deductible, calculated on a per individual basis, or as three times the individual deductible, calculated on an aggregate basis. The Schedule and the Non-Network Benefit provision must reflect the selected calculation. *Note*: All plans issued by a Carrier must reflect the same election.
15) The bracketed dispensing limit text contained in the network prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
16) The Pre-Existing Conditions exclusion may be omitted.
17) The Utilization Review Features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Insurance, pursuant to N.J.A.C. 11:21-4.2.
18) The "Alternate Treatment Feature" provision may be omitted. Carriers may provide for such "case management" administratively. If included in the form, the text must conform to the text of the standard form.

19) The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
20) The "Small Claims Waiver" section of the "Coordination of Benefits" provision may be omitted.
21) The refund formula specified in the "Premium Amounts" provision may be modified to specify alternate methods of calculation. (Contract Only)
22) Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
23) The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
24) The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.
25) Carriers may elect to omit the ERISA provisions.

The following explanations apply only to the Evidence of Coverage.

1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

EXHIBIT KK

(Fill out this form if company reported Accident and Health Premium to the New Jersey Department of Banking and Insurance for a calendar year but did not have in force health benefits plans covering small employers, whether written directly or through an association, trust or multiple employer arrangement. See definitions in N.J.A.C. 11:2-1.2. If company had in force health benefits plans in the calendar year, fill out Market Share Report, "Exhibit CC." Filing due before March 1)

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM
CERTIFICATION OF NON-MEMBER STATUS FOR CALENDAR YEAR____

Carrier Name _____
Address _____
_____

NAIC # _____

I, _____(print or type name)_____, a duly authorized officer of the above named entity, hereby certify that this entity:
(CHECK EITHER #1 OR #2)

_____ 1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2; or

_____ 2. Is a carrier that is not a "member" of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" in force in _____ (year) covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21-1.2. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for the stated year were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above (YOU MUST, IN THE SPACE BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 984-2425)

Signature of officer _____ Date _____
Title _____ Telephone Number _____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health
Benefits Program
PO BOX 325
Trenton, NJ 08625

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Administrative correction.
See: 30 N.J.R. 1047(a).