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 (N.J.S.A. 17B:27A-17 et seq.), 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).

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 (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Plans 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 the New Jersey Department of Insurance.

"Department" means the New Jersey Department of 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 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. § 300e et seq.)

"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. "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 or vision only;

8. Insurance issued as a supplement to liability insurance;

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

10. Hospital confinement or other supplemental limited benefit insurance coverage;

11. 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

12. Stop loss or excess risk insurance with per person retention limits of no less than $25,000 per year and/or aggregate retention limits of no less than 125 percent of expected claims per year.

"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.

"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.

"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 for small employers approved by the Commissioner pursuant to section 17 of P.L. 1992, c.162 (N.J.S.A. 17B:27A–33).

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973 c.337 (N.J.S.A. 26:2J–1 et seq.).

"Stop loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement of one or more small employers for catastrophic and unexpected expenses exceeding specified per person retention limits and/or aggregate retention limits, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

"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).

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 provide a mechanism:

1. To assure the availability of 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; and

2. Through which certain losses of specified member companies accruing under the five small employer health benefits plans will be reimbursed by other member companies that are subject to assessments.

(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 Insurance or their designees, both of whom shall serve as 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. 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. Two 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. A health maintenance organization;

5. A risk-assuming carrier;

6. A reinsuring carrier; and

7. 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).

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 members 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 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 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 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 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). 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 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.

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

"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.

"Reinsuring carrier" means a small employer carrier electing to receive reimbursement from the program in accordance with Section 19 of the Act (N.J.S.A. 17B:27A–35).

"Risk-assuming carrier" means a small employer carrier electing to assume risks pursuant to section 18 of the Act (N.J.S.A. 17B:27A–34).

"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. 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 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.

"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 for small employers approved by the commissioner pursuant to Section 17 of the Act (N.J.S.A. 17B:27A–33).

"State" means the State of New Jersey.

"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).

11:21–2.3 Powers of the Board

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

1. Develop the method to be used to determine the extent to which a reinsuring carrier's payment per insured for each health benefit plan provided for under the Act exceeds the Statewide average payment per insured for each health benefits plan provided for under the Act;

2. Develop the method for determining the extent to which a reinsuring carrier whose average cost of insuring individuals covered by small employer health benefits plans exceeds the threshold described in Section 13(c) of the Act (N.J.S.A. 17B:27A–29(c)) may receive reimbursement from the Program;

3. Develop a statement of the efficiency and risk management standards a reinsuring carrier must meet before a reinsuring carrier may receive reimbursement from the Program;

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

5. 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;

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

7. Establish guidelines to ensure that small employer carriers are assuming their share of high risk small employer groups in proportion to their market share of small employer health benefits plan business. In the event that any carrier does not assume its reasonable share of the high risk market, the Board may adjust the assessment formula, with the approval of the Commissioner, to require a proportionally higher assessment from the carrier;

8. 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;

9. 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;

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

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

12. 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;

13. 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;

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

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

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

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

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, 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. 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.

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.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. 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.

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 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).

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 five directors, but the Chair may appoint additional persons 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 Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments and other risk sharing charges;

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;

2. An Operations Committee which shall make recommendations to the Board with respect to:

i. The Plan and amendments thereto;

ii. A uniform reinsurance compliance audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;

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

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

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

vi. Developing the means to select a plan 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

vii. 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;

3. 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 questions 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;

4. 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

5. A Dispute Resolution Committee which shall make recommendations to the Board with respect to:

i. Consumer, policyholder and member carrier inquiries,complaints and disputes arising in connection with the Program;

ii. The manner by which the Board may address inquiries, complaints and disputes brought to its attention;

iii. Procedures for receiving, logging and handling inquiries, complaints and disputes;

iv. The design of inquiry, complaint and dispute forms;

v. Procedures for carriers to use in notifying the Board of complaints and disputes;

vi. 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 Dispute Resolution 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 Dispute Resolution Committee or Administrator may seek the input of other appropriate Committees in order to assist the Dispute Resolution Committee in reaching a recommendation.

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

(4) The Dispute Resolution Committee or Administrator shall compile statistics on complaints, disputes and appeals received and resolved and submit an annual report to the Board and the Commissioner detailing the volume of complaints, disputes and appeals categorized by type, carrier and disposition.

(5) Nothing in this paragraph shall be deemed to impair or otherwise affect the authority of the Commissioner to investigate and resolve any complaint or dispute or to take any regulatory or enforcement action with respect to any violations of any State insurance statutes or rules which come to the Commissioner's attention.

(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.

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 March; 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 in the established depository account(s) on a timely basis;

6. Reimbursing reinsuring carriers following their submission of acceptable documentation;

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

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

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

10. 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;

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

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

13. Based on minimum standards for participation in the Program as a reinsuring carrier developed by the Board, reviewing compliance with such standards; and

14. 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.

11:21–2.8 Assessments for administrative and operating expenses

(a) Annually on or about April 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.

11:21-2.9 Assessment for reimbursable losses

(a) The Board shall determine the total reimbursable losses, which shall be the net loss of the Program, if any, for the calendar year based upon the information submitted by reinsuring carriers annually on or before August 15 to the Board beginning in 1995. Such a determination shall be made by the Board on or about October 1 annually.

(b) The total reimbursable losses for the year shall be the aggregate of the reimbursable losses for all reinsuring carriers reporting reimbursable losses.

(c) Reinsuring carriers shall be liable for a portion of the reimbursable losses. A reinsuring carrier's assessment amount shall equal reimbursable losses but shall not exceed four percent of the earned premiums for small employer health benefits plans for any reinsuring carrier.

1. Each reinsuring carrier's assessment amount shall be determined by multiplying the total assessment amount by the ratio of the reinsuring carrier's earned premiums for that calendar year for small employer health benefits plans to the total earned premiums for that calendar year for all reinsuring carriers for small employer health benefits plans.

2. The Board shall provide notice to reinsuring carriers in writing on or about October 1 of the total reimbursable losses for the year and whether the reinsuring carrier may be liable for a portion of the total reimbursable losses.

3. The Board shall notify each reinsuring carrier of the assessment and reimbursement for reimbursable losses by invoice stating the dollar amount then due by November 1. As a result of the assessment, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

4. Assessment amounts for reinsuring carriers granted a deferral by the Commissioner, or subject to dispute by a carrier wherein the dispute is settled in favor of the disputing carrier, shall be apportioned to other reinsuring carriers based on their respective share of earned premiums for small employer health benefits plans.

5. A reinsuring carrier's assessments in amounts exceeding four percent of earned premiums shall be apportioned to all small employer carriers based upon their respective share of small employer health benefits plan earned premiums until such other members reach one percent of small employer health benefits plan earned premiums or the total reimbursable losses are fully assessed, whichever occurs first.

6. If a member that is not a reinsuring carrier demonstrates that it would have qualified for reimbursable losses if it had elected to be a reinsuring carrier, such carrier shall be eligible for a reduction in its assessment. Said reduction shall be equal to 1.00 minus the carrier's ratio of its earned premium for small employer health plans to the total earned premium for small employer health plans divided by the ratio of the carrier's reimbursable loss calculated above to the total of all calculated reimbursable losses. In no event shall this calculation cause the assessment to be increased.

7. Reductions in assessments made according to (c)6 above shall be apportioned to other members until such other members are assessed one percent of small employer health benefits plan earned premiums.

(d) Assessment amounts are due and payable upon receipt of an invoice by a member 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 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

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

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

iii. If a member makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due. Errors that are reported and paid in full to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth above.

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 when due, 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.

(e) 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.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice 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.

2. 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.

(f) The Board shall approve the disbursement of any payments to those members determined by the Board as having reimbursable losses. Disbursement shall be in proportion to the member's share of the total reimbursable losses, until all such available funds have been paid out, or a member's reimbursable losses have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed to members having reimbursable losses until such time as the dispute has been settled or concluded with 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 to members having reimbursable losses along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carriers 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 or late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

(g) Assessment amounts shall be redistributed to the appropriate reinsuring carriers for their losses on or about December 1 of each calendar year.

(h) 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.

(i) 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.

(j) A reinsuring carrier may apply to the Board for reimbursement from the program if such reinsuring carrier demonstrates to the Board that it has satisfied the efficiency and risk management standards promulgated by the Board, as set forth herein, and demonstrates it has incurred an average cost of insuring individuals covered by small employer health benefits plans that exceeds the Statewide average payment per insured by 20 percent. A reinsuring carrier satisfactorily demonstrating it has met these threshold standards may seek reimbursement from the Program for the lesser of its actual losses or 80 percent of the excess of its incurred claims over 120 percent of the Statewide average payment per insured, as defined herein, multiplied by the number of insured months for the reinsuring carrier.

(k) Before a member may receive reimbursement from the Program, the member must demonstrate to the Board's satisfaction, subject to its review and audit by the Board, that it has conducted its business operations with respect to administering its small employer health benefits plans in accordance with generally accepted industry practice and has made good faith efforts to apply sound risk management principles in an efficient manner.

1. Such risk management and efficiency standards shall include, but are not limited to, claim processing and payment practices showing the member has:

i. Paid or declined for payment 85 percent of all claims within 10 working days from the date the completed submission was received;

ii. Reviewed a statistically valid sample of claims on a regular basis for accuracy and proper use of the reimbursement methodology, with dollar accuracy, without allowance for offsets of over/under payments, being at least 99.0 percent; and

iii. Responded to all inquiries from insureds or covered individuals within 30 business days.

2. A member shall apply its case management and claims handling techniques and other methods of operation in the same manner with respect to all its business.

(*l*) Statewide average payment per insured means the ratio of the claims incurred in the calendar year for all members to the total number of insured months for that calendar year for all members calculated separately for each small employer health benefits plan.

1. A carrier's average payment per insured means the ratio of the claims incurred in the calendar year to the total number of insured months for that calendar year calculated separately for each small employer health benefits plan.

2. The extent to which that carrier's average payment per insured for the small employer health benefits plan exceeds the Statewide average payment per insured for the small employer health benefits plan shall equal the difference between the carrier's average payment per insured and the Statewide average payment per insured for a given small employer health benefits plan.

3. The calculations shall be performed after the close of the calendar year at a time which the Board establishes that most claims incurred will have emerged.

(m) In order to ensure small employer carriers are assuming their share of high risk employer groups in proportion to their share of the small employer health benefits plan business, the Board shall charge the appropriate Committee(s) with conducting a survey of the market beginning sometime after the first full calendar year of operation under the Program to measure and define the proportion of high risk small employer groups within the small employer group health market and to determine the distribution of such groups among the members in the market. Based on this survey, the Board shall request that the appropriate Committee(s) assess the reasons for any member's disproportionately low share of such high risk groups.

1. Based on the findings, the Board shall consider appropriate steps to ensure each member's share of the high risk market is proportionate to its total small employer health benefits plan business and shall, based upon the survey data, direct the Finance Committee to develop suitable mechanisms for adjusting the assessment formula to require a proportionately higher assessment for members not assuming their reasonable share of the high risk market. The Board shall further determine the best means of regularly ensuring the proportionate distribution of high risk groups among members for subsequent years of the Program's operation.

2. The Board shall set forth within this Plan the standards and procedures used to adjust the assessment formula and/or means to ensure the proportionate distribution of high-risk groups in subsequent years.

11:21–2.10 Reporting requirements

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

11:21–2.11 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. Net losses of the Program calculated in accordance with this Plan;

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

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

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

v. 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. 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 the Director of the Division of Budget and Accounting, to the Program's bank accounts upon request by the Board through the Department, which request shall include a justification for the request, with supporting documentation.

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) Bank checking 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.

11:21–2.12 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.

11:21–2.13 Audit functions

(a) The necessity for and the frequency of audits of carriers shall be determined by the Board. The reasonable cost of the audit of a carrier shall be borne by that carrier. The Board shall have the right to conduct appropriate additional audits of carriers.

1. All information disclosed in the course of the audit of a carrier shall be kept privileged and protected by the carrier, the auditing firm, and the Program, to the extent permitted by law.

2. Any information disclosed in the course of the audit may be used by the Board or Department to effectuate the provisions of this Act.

(b) 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;

2. The annual fiscal report of the Program; and

3. The calculation and collection by the Program of any assessments of carriers for net losses.

11:21–2.14 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.

11:21–2.15 Indemnification

(a) The Board shall not be liable for any obligation of the Program. No Director, officer, or employee of the Board or the Department or Department of Health shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

(b) The Program shall adopt additional procedures for indemnifying the Directors and any officers or employees, as the Board deems appropriate, which procedures shall be so forth in this Plan.

11:21–2.16 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.

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21–3.1 Benefits provided

(a) The small employer 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 terms of Plans B, C, D and E which are common among the plans; and

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

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall only 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. 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. The family deductible limit must be satisfied by two separate covered persons;

ii. $500.00 per covered person and $1,000 per covered family. The family deductible limit must be satisfied by two separate covered persons; and

iii. $1,000 per covered person and $2,000 per covered family. The family deductible limit must be satisfied by two separate covered persons.

2. Members offering Plan E shall offer only an annual deductible of $150.00 per covered person and $300.00 per covered family. The family deductible limit must be satisfied by two separate covered persons.

(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 small employer health benefits Plans B, C, D and E and the HMO Plan 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 and out-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 small employer 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.

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 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 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 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 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 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 optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by standard health benefit Plans A, B, C, D, and E or HMO, subject to the provisions set forth in (d)1 through 5 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of standard health benefit Plans A, B, C, D, E or HMO, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until 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 standard health benefit Plans A, B, C, D, E or HMO, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. In addition to (d)1 and 2 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.

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

i. Submit an original and seven copies of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21–1.3, and one copy to the Commissioner, if required by (d)1 above, at the New Jersey Department of Insurance, Office of the Life and Health Actuary, 20 West State Street, CN–325, Trenton, New Jersey, 08625, Attn: SEH Optional Benefit Rider Filing;

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 or HMO 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 benefit or a decrease in the actuarial value of standard health benefits Plan A, B, C, D, E, or HMO 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; and

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

5. 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).

SUBCHAPTER 3A. NON–STANDARD HEALTH BENEFITS PLANS

Authority

N.J.S.A. 17B:27A–17 et seq., as amended by N.J.S.A. 17B:27A–51 and P.L. 1994, c.11.

Source and Effective Date

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

11:21–3A.1 Purpose and scope

This subchapter establishes which non-standard health benefits plans may be issued, renewed, reinstated or continued pursuant to P.L. 1994, c.11, and specifies the standards which shall apply to the issuance, renewal, reinstatement 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 or N.J.A.C. 11:21–1.2 unless defined below or the context clearly indicates otherwise.

"Anniversary date" and "12–month anniversary date" means:

1. With respect to coverage of a small employer who has coverage other than as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract:

i. The annual 12–month renewal date following the initial effective date of coverage for that small employer under the policy or contract; or

ii. If such annual renewal date has been changed prior to April 4, 1994 and thus no longer is the same calendar date and with the initial effective date, the new annual renewal date;

2. With respect to coverage of a small employer as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract, wherein there is no common renewal date established for coverage of all such member small employers;

i. The annual 12–month renewal date following the initial effective date of coverage for that small employer; or

ii. If such annual renewal date has been changed prior to April 4, 1994, and thus no longer coincides with the initial effective date, the new annual renewal date; or

3. With respect to coverage of a small employer covered as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract, wherein there is a common renewal date established for coverage of all such small employers notwithstanding each small employer's initial effective date;

i. The common renewal date; or

ii. If the common renewal date has been changed prior to April 4, 1994, the new common renewal date.

"Non-standard health benefits plan" means 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.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board and set forth at N.J.A.C. 11:21–3.1.

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

(a) During the period beginning on April 4, 1994 and ending on September 10, 1994, 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, pursuant to P.L. 1994, c.11.

(b) Beginning on September 11, 1994, 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, subject to the following:

1. On the first anniversary date of a small employer's coverage under the non-standard health benefits plan occurring on or after September 11, 1994, 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. A small employer shall have the option to renew or continue a non-standard health benefits plan on any anniversary occurring between February 28, 1994 and February 28, 1996. Such non-standard health benefits plan may at the employer's option remain in effect until the end of the policy or contract year that begins on the 12–month anniversary date occurring on or before February 28, 1996.

3. The non-standard health benefits plan shall not be amended or modified, except as (b)1 above may require and except for the purpose of changing deductible or copayments for the non-standard health benefits plan.

4. The carrier, association, multiple employer arrangement or out-of-State trust shall file such renewed or continued non-standard health benefits plan with the Commissioner in accordance with N.J.A.C. 11:21–8.

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

(a) A non-standard health benefits plan whose anniversary occurred March 1, 1994 through April 4, 1994 may be reinstated, at the option of the small employer policy or contract holder, by providing written notice to the carrier within 60 days of that anniversary date.

(b) A non-standard health benefits plan that is reinstated in accordance with subsection (a) may be renewed in accordance with and subject to the provisions of N.J.A.C. 11:21–3A.3.

11:21–3A.5 New issuance of non-standard health benefits plans

(a) A carrier shall not offer or issue a non-standard health benefits plan to a small employer except through an association, multiple employer arrangement or out-of-State trust in accordance with this section.

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

1. Was available for purchase through the association, multiple employer arrangement or out-of-State trust to its members on December 31, 1993;

2. If issued during period beginning on April 4, 1994 and ending on September 10, 1994, complies with the requirements of N.J.A.C. 11:21–3A.3;

3. If issued on or after September 11, 1994, complies with the requirements of N.J.S.A. 17B:27A–18, 19b, 22, 23, 24, 25 and 27 upon the date of issue;

4. Shall not be amended or modified except as necessary to comply with (b)2 and 3 above, or for the purpose of changing deductible or copayments;

5. Shall remain available for renewal, at the option of the small employer through the 12–month anniversary date which occurs on or before February 28, 1996; and

6. If issued or renewed on or before February 28, 1996, shall, at the option of the small employer, remain in effect until the 12–month anniversary date which occurs on or before February 28, 1997.

(c) An association, multiple employer arrangement or out-of-State trust may offer and issue a non-standard health benefits plan pursuant to (b) above, if the association, multiple employer arrangement or out-of-State trust complies with the following:

1. The non-standard health benefits plan shall be offered and issued only to a small employer, as defined in N.J.S.A. 17B:27A–17 and rules promulgated pursuant to the Act, that is a member of that association, multiple employer arrangement or out-of-State trust;

2. No non-standard health benefits plan shall be offered, issued or renewed after February 28, 1996;

3. An association, multiple employer arrangement or out-of-State trust also shall offer and, if accepted, issue standard health benefits plans to all of its small employer members; and

4. An employee's actual or expected health status shall not be used in determining whether to offer or issue a non-standard health benefits plan to any member small employer or to offer or issue coverage to employees, or their dependents, of any small employer.

(d) A carrier, association, multiple employer arrangement or out-of-State trust may offer or issue coverage under a non-standard health benefits plan to new employees of a small employer that was covered under a non-standard health benefits plan on February 28, 1994, and remain covered under such a non-standard health benefits plan, subject to the following:

1. A carrier, association, multiple employer arrangement or out-of-State trust shall not discriminate between small employers in making the offer or issue; and

2. A carrier, association, multiple employer arrangement or out-of-State trust shall not discriminate between a small employer's eligible employees in making the offer or issue.

11:21–3A.6 Cessation of issuance, renewal or continuation of non-standard health benefits plans; conversion to small employer health benefits plans

No non-standard health benefits plan may be issued or renewed in accordance with this subchapter after February 28, 1996. No non-standard health benefits plan issues, renewed or continued in accordance with this subchapter may remain in effect after the 12–month anniversary date which occurs on or before February 28, 1997. At least 60 days prior to the non-standard health benefits plan's final 12–month anniversary date, the carrier shall provide to the small employer notice that the existing policy or contract will be cancelled on its anniversary date. The carrier shall give the small employer an outline of the standard health benefits plans and the premium cost for the standard health benefits plan which is most equivalent to that policy or contract which will be cancelled. Upon request of the small employer, the small employer carrier shall provide the premium costs with respect to the other standard health plans pursuant to N.J.A.C. 11:21–7.10.

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 fine 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) In issuing 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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."

(i) 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."

(j) 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).

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, in triplicate, completed Certification of Compliance forms, set forth in Part 1 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference.

2. Completed Certification of Compliance forms shall be submitted to the Board at the address set forth at N.J.A.C. 11:21–1.3, and to the Commissioner at the following:

Attn: SEH Form Certification of Compliance
Division of Life and Health Actuarial Services
New Jersey Department of 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 as specified at N.J.A.C. 11:21–4.1 with copies in triplicate 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).

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 contract, certificates, and evidence of coverage for Plans A, B, C, D, E and HMO 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 contract, certificates, evidence of coverage, or standard riders promulgated by the Board. Nothing contained in this section shall prevent a member from issuing a standard policy form, HMO contract, certificates, 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 contract, certificates, and evidence of coverage for Plans A, B, C, D, E and HMO and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K to the chapter 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).

SUBCHAPTER 5. STANDARD CLAIM FORM

11:21–5.1 Standard Claim Form

(a) All members offering health benefits plans to small employers shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claim form approved by the Board and set forth as 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–82 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.

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 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).

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.

"Health benefits plan" includes:

1. A standard health benefits plan;

2. From September 11, 1994 until the third anniversary date following February 28, 1994, a non-standard health benefits plan renewed, reinstated or continued in accordance with N.J.A.C. 11:21–3A.3 or 11:21–3A.4; and

3. From September 11, 1994 until the 12–month anniversary date which occurs on or before February 28, 1997, a non-standard health benefits plan issued in accordance with N.J.A.C. 11:21–3A.5.

"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.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to the review and approval of the Commissioner, whether or not modified by rider.

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

11:21–7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21–3A.1 et seq. 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 standard health benefits plans that are issued or renewed on or after January 1, 1994, and all non-standard health benefits plans that are renewed or issued in accordance with N.J.A.C. 11:21–3A.3 or 11:21–3A.5, respectively, on or after September 11, 1994, 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 geographic location of the employees of the small employer, except that:

i. The small employer carrier shall refuse to issue coverage to a small 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.

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 qualified 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.

(b) Except as otherwise provided in N.J.A.C. 11:21–3A.5 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 N.J.A.C. 11:21–3A.3 or 11:21–3A.4 and/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 N.J.A.C. 11:21–3A.3 or 3A.4 and/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 N.J.A.C. 11:21–3A.3 or 3A.4, 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).

11:21–7.4 Carriers acting as administrators for small employers

(a) A small employer carrier may act as administrator for a small employer's self-funded plan and shall not be considered to be acting in circumvention of N.J.S.A. 17B:27A–17 et seq. if the small employer's self-funded plan meets the definition of an employee welfare benefit plan at 29 U.S.C. 1002(1) and is not a multiple employer welfare arrangement, in whole or in part, as defined at 29 U.S.C. 1002(40).

(b) A small employer carrier may act as administrator for a self-funded plan for a group of small employers and shall not be considered to be acting in circumvention of N.J.S.A. 17B:27A–17 et seq., if the group of small employers meets the requirements of 29 U.S.C. 1002(40)(B), establishing the criteria of what constitutes a control group single employer for the purposes of the federal Employee Retirement Income Security Act.

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).

11:21–7.5 Restrictions on replacement of health benefits plans

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

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

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

(d) In the event that the previous standard 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 standard 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 standard 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).

11:21–7.6 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. An eligible employee who 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 plan, or is covered under an indemnity plan or any HMO plan offered by the small employer, shall be counted as covered under the small employer's health benefits plan for the purpose of satisfying participation requirements.

(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).

11:21–7.7 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).

11:21–7.8 Preexisting condition standards

(a) A health benefits plan covering 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 previous hospital and medical expense insurance policy or certificate; or health, hospital or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in the United States, 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) 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).

11:21–7.9 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).

11:21–7.10 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.

11:21–7.11 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.

11:21–7.12 Guaranteed 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 em-

ployees 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. The number of employees covered under the health benefits plan is less than two;

7. 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

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

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

11:21–7.13 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 dependent units 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, and HMO;

2. The number of health benefits plans in force by three digit zip code 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 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 each standard health benefits plan A, B, C, D, E, and HMO;

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, and HMO;

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.

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

11:21–7.14 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.

11:21–7.15 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).

SUBCHAPTER 7A. (RESERVED)

Subchapter Historical Note

Subchapter 7A, formerly 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 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 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 or other entities are not members of the SEH Program and how those carriers or entities 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.

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 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.)

"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 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.

11:21–8.3 Non-member status

(a) A carrier or other entity shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification if the non-member certification is approved by the Board.

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

1. The carrier or entity 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. The carrier:

i. Has issued only one group health insurance policy in New Jersey;

ii. Issued the policy exclusively to the members of an association, as defined and authorized by N.J.S.A. 17B:27–27, 28 or 29, or N.J.S.A. 17B:27–8;

iii. Issued the policy on or before November 30, 1992;

iv. Issued the policy in the name of the association; and

v. Currently insures under the policy more than 49 certificateholders who are members of the association; or

3. 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).

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, except that, to be considered a non-member for calendar year 1993, a carrier or entity shall file a completed request for non-member certification no later than April 15, 1994. 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 be certified by a duly authorized officer of the carrier or other entity and shall include an affirmative statement that the carrier or entity had no group health benefits plan covering New Jersey small employers in force during the calendar year for which non-member status is requested, or shall set forth the other reason(s) under law why the carrier or entity qualifies as a non-member.

(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 Insurance
CN 325
Trenton, NJ 08625–0325

11:21–8.5 Decisions on filings by the Board

The Board shall grant or deny requests 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 or other entity and to the Commissioner.

11:21–8.6 Review

(a) A carrier or other entity 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.

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

Authority

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

Source and Effective Date

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

11:21–9.1 Purpose and scope

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

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

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

11:21–9.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ii. The assumptions used in developing the anticipated loss experience, including trend, plan relativity assumptions and the anticipated distribution of business by rating classification described in (a)2 above and any other factors used; and

iii. If the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A–25g(2), the carrier shall also submit the following:

(1) The assumptions for claim adjudication and payment expense, other administrative expenses, commissions, premium taxes, federal income taxes, risk margin, profit margin and any other margins applicable to the filing;

(2) The assumptions for anticipated investment income; and

(3) The assumptions and the carrier's practices for distributing anticipated divisible surplus including a statement explaining how divisible surplus will be determined and paid; and

4. A certification signed by a member of the American Academy of Actuaries attesting to the accuracy and completeness of the information provided pursuant to (a)1, 2 and 3 above and of the following information which shall also be included:

i. A statement that the filing is complete;

ii. The issue period for which the filed rates are effective, which shall not exceed 12 months;

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

iv. A statement of the anticipated incurred loss ratio for each plan and deductible option which shall not be less than 75 percent of the premium therefor;

v. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1994 through December 31, 1995, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 300 percent of rates (for an individual and for each family status) produced for the lowest rated group for each policy form (plan and deductible);

vi. For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996 through December 31, 1996, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 200 percent of rates (for an individual and for each family status) produced for

the lowest rated group for each policy form (plan and deductible option);

vii. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1997, a statement that each policy form (plan and deductible option) is community rated for each rating tier (individual, husband/wife, parent/child(ren) and family).

viii. Whether the policies provide that the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A–25g(2); and

ix. A statement that the factors which will be used to establish claim reserves are appropriate.

(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, 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, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21–7.15.

(c) All carriers renewing policies, contracts or certificates under a nonstandard health benefits plan (or issuing policies, contracts or certificates under a nonstandard health benefits plan through an association, multiple employer arrangement or out-of-State trust) after September 11, 1994, prior to renewing (or issuing) 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, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21–7.15.

(d) 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, except that any change in rates intended to occur after September 11, 1994 shall be filed in compliance with (b) or (c) above, as appropriate.

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

11:21–9.4 Informational filing procedures

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

Attention: SEH Informational Filings
Division of Life/Health Actuarial Services
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, NJ 08625–0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 30 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 30 days of the date of submission thereof, the informational 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).

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 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.)

"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 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.

11:21–10.3 Filing of the Market Share Report

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

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

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

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

11:21-10.4 Net earned premium

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

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

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

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

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

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

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

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

11:21-10.5 Certification

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

11:21-10.6 Failure to comply

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

SUBCHAPTER 11. NONSTANDARD HEALTH BENEFITS PLAN FILINGS WITH THE COMMISSIONER: FORM FILINGS AND REQUEST TO WITHDRAW PLAN FORMS

Authority

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

Source and Effective Date

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

11:21-11.1 Purpose and scope

(a) This subchapter defines those health benefits plans that were in effect on December 31, 1993 which a carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw with respect to small employer policy or contractholders prior to February 28, 1997, without the approval of the Commissioner in accordance with P.L. 1994, c.11, except as N.J.S.A. 17B:27A-23 may apply.

(b) This subchapter defines those health benefits plans which were in effect on December 31, 1993 and have been or will be renewed, continued or reinstated that shall be filed with the Commissioner for informational purposes in accordance with P.L. 1994, c.11, § 3j.

(c) This subchapter establishes the procedures for making a request to the Commissioner to withdraw a nonstandard health benefits plan for reasons other than those specified at N.J.S.A. 17B:27A-23, and the standards for review and approval of the request.

(d) This subchapter establishes the procedures for making a complete informational filing of nonstandard health benefits plans with the Commissioner, and the standards for review of the filings submitted.

11:21-11.2 Definitions

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

"Market" or "marketed" means to offer or have offered or advertised as available a nonstandard health benefits plan for initial purchase by small employers.

"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.

"Substantial threat to a carrier's financial condition" means that a carrier is in a hazardous financial condition as specified in N.J.A.C. 11:2–27, or that a carrier is financially impaired, meaning that a carrier, after the effective date of this subchapter, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or is placed under an order of receivership, rehabilitation or conservation by a court of competent jurisdiction.

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

11:21–11.3 Restricted withdrawal and marketing

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw a nonstandard health benefits plan before March 1, 1997 without prior approval of the Commissioner if there was one or more policies or contracts in force under that nonstandard health benefits plan on December 31, 1993, and the nonstandard health benefits plan was marketed to small employers as of December 31, 1993, except as (b) below applies.

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

(c) A carrier shall not market a nonstandard health benefits plan subject to (a) above except as (d) below applies.

(d) An association, multiple employer arrangement or out-of-State trust shall not be required to market a nonstandard health benefits plan subject to (a) above; however, an association, multiple employer arrangement or out-of-State trust that does market a nonstandard health benefits plan to its members' employees and dependents shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust, and in no instance shall actual or expected health status be used in determining membership.

11:21–11.4 Request to withdraw nonstandard health benefits plans

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

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

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

(b) A carrier may submit a single filing to request withdrawal of more than one nonstandard health benefits plan, but shall clearly specify each nonstandard health benefits plan for which a withdrawal is sought.

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

1. A cover letter stating:

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

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

iii. A statement of facts relied upon as the basis under which the request is sought, including the specific factor(s) upon which the Commissioner may find that there is a substantial threat to the carrier's financial condition, specifically using the criteria set forth in N.J.A.C. 11:2–27.3(a)1 to 29;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation not to withdraw the nonstandard health benefits plan(s) prior to March 1, 1997 would have on the immediate and long term financial condition of the carrier unless the request to withdraw is approved;

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

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

5. If the carrier is a member of a holding company system:

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

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

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

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the carrier

transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the carrier (if the carrier is a health maintenance organization, the carrier shall obtain and file an actuarial opinion which complies with these requirements);

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

8. A copy of the annual statement of the carrier, including all accompanying exhibits, filed with this State immediately preceding the date of the request to withdraw;

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

10. Three-year financial projections beginning with the calendar year of the date of the filing assuming both that the request to withdraw is granted and that it is denied. The projections shall include the following:

i. In summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the carrier in making the projections;

ii. Results for the carrier's operations worldwide by line of business and for the carrier's operations in New Jersey only for health benefits plans issued, renewed, continued or reinstated pursuant to N.J.S.A. 17B:27A–17 et seq.;

iii. Assumptions that the rate of assessments for the carrier in the three year projections shall be the same as the assessments received by the carrier in the year in which the request to withdraw is filed; and

iv. Projections of the carrier's operating results containing the information and in the format set forth in the following:

(1) For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the carrier;

(2) For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the carrier;

(3) For health service corporations, hospital service corporations and medical service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the service corporation; and

(4) For health maintenance organizations, the balance sheet and statement of revenue, expenses and net worth of the annual statement filed by the health maintenance organization.

11. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted;

12. A statement specifying the method (either cancellation or nonrenewal) to be used for the withdrawal, with a certification that the withdrawal shall comply with the standards of N.J.A.C. 11:21–11.6; and

13. Any other information the Commissioner may deem relevant to the consideration of the request.

(d) A carrier asserting that the Department's review of its request be evaluated on a specific basis (that is, pre-pooled, post-pooled, consolidated, or unconsolidated), shall submit a written statement which sets forth the specific reasons, with supporting documentation, if any, for which it believes evaluation on a specific basis is appropriate to that carrier, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(e) All requests to withdraw shall be accompanied by the following certification signed by the chief financial officer of the carrier: "I, (the signatory's name), hereby certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:21–11.4 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of (the Company name)."

(f) All requests to withdraw shall be accompanied by a non-refundable filing fee of $1,000, unless the carrier is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32–31 et seq. or such similar law of the carrier's state of domicile, and the submission includes a statement to that effect, and shall be filed with the Department at the following address:

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

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

11:21–11.5 Review and approval of a request to withdraw

(a) The Department shall deny a request to withdraw if the request fails to substantially comply with the filing format and information requirements set forth in N.J.A.C. 11:21–11.4. The Department shall notify the carrier in writing that its request to withdraw is deficient on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(ies). If the carrier intends to pursue its request to withdraw, the carrier shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in N.J.A.C. 11:21–11.4 within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the required information shall result in the carrier's request being denied without prejudice.

(b) When the Commissioner determines pursuant to (c) below that the carrier is or would be placed in a financially impaired condition because of the requirement to continue servicing the nonstandard health benefits plan(s) specified in the request to withdraw, the Commissioner shall notify the carrier in writing that it may withdraw the specified nonstandard health benefits plan(s), subject to the standards of N.J.A.C. 11:21–11.6.

(c) The Commissioner shall find that there is a substantial threat to a carrier's financial condition if:

1. The carrier has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32–31 et seq., or such similar law of the carrier's state of domicile;

2. The Commissioner finds that the carrier is in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27; or

3. The Commissioner finds that a denial of the request to withdraw the specified nonstandard plan(s) would place the carrier in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27.

(d) If the Commissioner denies a carrier's request to withdraw made pursuant to the provisions of N.J.A.C. 11:21–11.4, the carrier may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

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

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A statement describing in detail the basis for which the carrier believes that the Commissioner's denial is erroneous.

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

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

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

ii. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(e) All data or information contained in the request to withdraw shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A–1 et seq., except for the following items which shall only be released upon written, specified request and following 10 days written notice by the Department to the carrier:

1. The cover letter naming the carrier and describing the request to withdraw;

2. The name, title, telephone number and telefax number of a person familiar with the filing;

3. The most recent financial examination report;

4. The list of members of holding company systems and intercompany transactions for the period preceding the date of the filing;

5. The annual statement filed immediately preceding the date of the filing; and

6. The non-refundable filing fee.

11:21–11.6 Standards for the process of withdrawal of a nonstandard health benefits plan either by cancellation or nonrenewal

(a) Carriers shall specify in their request to withdraw, as required by N.J.A.C. 11:21–11.4(c)12, whether they shall effect the withdrawal of the specified nonstandard health benefits plan(s), if the request is granted, through nonrenewal or cancellation of the policies, contracts or certificates issued under the nonstandard health benefits plan(s). A carrier shall effect its withdrawal through only one of the two methods.

(b) Carriers may elect to withdraw by nonrenewing policies, contracts or certificates at the time of the 12–month

anniversary date of each such policy, contract or certificate, provided that:

1. Each policyholder, contractholder or certificateholder is given 60 days written notice prior to the date of the nonrenewal;

2. The notice specifies the reasons for the nonrenewal (that is, that withdrawal of the health benefits plan has been approved by the Commissioner pursuant to this subchapter);

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

4. The notice contains the name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information concerning the withdrawal;

5. Notice of the withdrawal is provided to the producer of record for each policy, contract or certificate within 60 days of the date that the request to withdraw is granted;

6. The withdrawal of the nonstandard health benefits plan shall be completed within 14 months of the date that the request to withdraw is granted; and

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

(c) A carrier may elect to withdraw by cancelling the policies, contracts or certificates issued under a nonstandard health benefits plans, provided that:

1. Each policyholder, contractholder or certificateholder is given no less than 60 days written notice prior to the date of the cancellation;

2. The notice specifies the reason for the cancellation;

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

4. The notice includes the name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal;

5. Notice of the withdrawal is provided to the producer of record for each policy, contract or certificate within 60 days of the date that the request to withdraw is granted;

6. The date of cancellation shall be uniform for all policyholders, contractholders and certificateholders under a nonstandard health benefits plan;

7. The date of cancellation of each nonstandard health benefits plan that is the subject of the request to withdraw shall be no later than six months following the date that the request to withdraw is granted; and

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

(d) At the time of the filing of the request to withdraw, a carrier shall specify which of the two methods it shall use, and shall include in the filing the notice that it will provide to its policyholders, contractholders, and certificateholders.

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

11:21–11.7 Other policyholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract of a health benefits plan that is the subject of a request to withdraw.

11:21–11.8 Informational filing of nonstandard health benefits plans

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

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

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

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

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

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

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

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

11:21–11.9 Penalty and fines

(a) A carrier failing to obtain prior approval of a withdrawal of a nonstandard health benefits plan in accordance with this subchapter, or initiating a withdrawal of a nonstandard health benefits plan that fails to conform with the requirements of N.J.A.C. 11:21–11.6 shall be subject to penalties and fines as follows:

1. The carrier shall offer to reinstate any and all policyholders, contractholders and certificateholders under each nonstandard health benefits plan, including any riders or endorsements which may have attached thereto, that is the subject of a violation under this subchapter; and

2. The carrier shall incur and remain liable for, until paid in full, a fine of $1,000 per each policyholder, contractholder or certificateholder nonrenewed or cancelled.

(b) A carrier failing to submit any completed certification required by N.J.A.C. 11:21–11.8 shall be subject to payment of a fine not less than $2,000 nor more than $5,000 per violation.

(c) Carriers assessed penalties or fines may request a hearing in accordance with N.J.A.C. 11:21–11.5(d).

SUBCHAPTERS 12 THROUGH 13. (RESERVED)

SUBCHAPTER 14. DECLARATION AND APPROVAL OF REINSURING OR RISK-ASSUMING CARRIER STATUS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:27A–34 and 17B:27A–46.

Source and Effective Date

R.1993 d.551, effective October 15, 1993.
See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a).

11:21–14.1 Purpose and scope

This subchapter establishes the rules applicable to all carriers requesting to operate as a risk-assuming and reinsuring carrier under the Program, and sets forth the standards for approval of risk-assuming applications by the Commissioner.

11:21–14.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2, when used in this subchapter, shall have the meanings as defined by the Act or for the chapter, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

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

"Health maintenance organization" or "HMO" means a company operating in accordance with N.J.S.A. 26:2J–1 et seq.

"Health service corporation" is a company operating in accordance with N.J.S.A. 17:48E–1 et seq.

"Hospital service corporation" is a company operating in accordance with N.J.S.A. 17:48E–1 et seq.

"Insurer" means a company transacting the business of health insurance as defined at N.J.S.A. 17B:17–4.

"Medical service corporation" is a company operating in accordance with N.J.S.A. 17:48A–1 et seq.

"Permissive election" means that election which carriers may make to be a risk-assuming carrier or reinsuring carrier, notwithstanding any previous affirmative or deemed election, pursuant to P.L. 1994, c.11, and as specified at N.J.A.C. 11:21–14.4(b). The "permissive election period" is that period which runs from July 15 through December 21, 1994.

"Reinsuring carrier" means a small employer carrier issuing small employer health benefits plans on a guaranteed issue basis that has elected pursuant to N.J.S.A. 17B:27A–34 or P.L. 1994, c.11, § 6 and this subchapter to be eligible for reimbursement of losses it may incur under those small employer health benefits plans as well as to be responsible for payment of assessments for reimbursable losses incurred by other reinsuring carriers.

"Relief" means a deferral of obligation granted pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations granted in accordance with N.J.S.A. 17B:27A–26.

"Risk-assuming carrier" means a small employer carrier issuing small employer health benefits plans that has elected and been approved by the Commissioner pursuant to N.J.S.A. 17B:27A–34 or P.L. 1994, c.11, § 6 and this subchapter to cover risks on a guaranteed issue basis without being subject to assessments for net reimbursable losses of the SEH Program incurred by reinsuring carriers which total the first four percent or less of the aggregate premiums from health benefits plans issued by reinsuring carriers, and is not eligible for reimbursement of any losses it may incur under its small employer health benefits plans.

"Statutory election period" means the period of time specified at N.J.S.A. 17B:27A–35b, or P.L. 1994, c.11, § 6 with respect to elections made pursuant thereto, for which an election to be a reinsuring carrier is binding. The initial "statutory election period" is that period in which carriers made their election on or before October 4, 1993, or within 30 days following the date that the Board submitted its Plan of Operation to the Commissioner, whichever date was later, which election shall be effective for two years. The secondary "statutory election period" is that period authorized by P.L. 1994, c.11, § 6, in which carriers make their permissive election which election shall be effective for two years. Otherwise, the "statutory election period," which shall be binding for five years, is that period that shall be applicable to any reinsuring carrier election made on or after the initial or secondary statutory election period.

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

11:21–14.3 General requirement

Each carrier, including each carrier among affiliated carriers, which is or becomes a small employer carrier, shall submit the information required by this subchapter independently from any other carrier. To the extent that any carrier's information is insufficient to meet the requirements of this subchapter, the carrier may submit the required information incorporating appropriate data from all of its affiliated carriers, if any, and so indicated on the form(s) submitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Every carrier filing for risk-assuming carrier status shall complete in full the Risk–Assuming Application Form

set forth in Exhibit U, Part 3 of the Appendix to this chapter, incorporated herein by reference.

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

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

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

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

i. The number of group contracts in force annually;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11:21–14.7 Standards for approval

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

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

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

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

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

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

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

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

3. The carrier has either:

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

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

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

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

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

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

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

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

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

11:21–14.8 Hearings

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

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

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

2. A copy of the notice of disapproval;

3. A statement requesting a hearing; and

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

(c) Upon receipt of a properly completed request for a hearing which sets forth good-faith, disputed issues of material fact, the Commissioner shall transmit the matter to the

Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

Authority

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

Source and Effective Date

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

11:21–15.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A–38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A–26.

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

11:21–15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

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

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A–17 et seq.

"Financially impaired" means a member which, after November 5, 1993, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A–26, as applicable.

11:21–15.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A–38 shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:21–15.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:21–15.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

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

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

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

11:21–15.4 Informational filing requirements

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

1. A cover letter stating:

i. The name of the applicant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Three year financial projections beginning with the calendar year of the date of the filing assuming relief is granted and assuming relief is denied. The projections shall include, in summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the applicant in making the projections. The projections shall include results for the applicant's operations worldwide by line of business and for the applicant's operations in New Jersey only for health benefits plans issued pursuant to N.J.S.A. 17B:27A–17 et seq. The projections shall assume the same rate of assessment as in the first year for the subsequent years, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

i. For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the insurer;

ii. For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the insurer;

iii. For health service corporations, hospital service corporations and medical service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the service corporation; and

iv. For health maintenance organizations, the balance sheet and statement of revenue, expenses and net worth of the annual statement filed by the health maintenance organization;

11. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted;

12. A non-refundable filing fee of $1,000, unless the applicant is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32–31 et seq. or such similar law of the applicant's state of domicile; and

13. Any other information the Commissioner may deem relevant to the consideration of the request.

(b) An applicant asserting that the Department's review of its request be evaluated on a particular basis (that is, pre-pooled, post-pooled, consolidated or unconsolidated), shall submit a written statement which sets forth the specific reasons, with supporting documentation, if any, for which it believes evaluation on a particular basis is appropriate to that applicant, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I _____ certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:21–15 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the applicant."

11:21–15.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A–1 et seq., except for the following items, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

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

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

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

4. N.J.A.C. 11:21–15.4(a)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;

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

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

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

11:21–15.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A–26b or 17B:27A–38 as applicable, that the member is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A. 17B:27A–38, the member shall remain liable to the SEH Program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the SEH Program if it fails to pay assessments.

(b) The Commissioner shall find that a member is or would be financially impaired if:

1. The member has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32–31 et seq. or such similar law of the member's state of domicile;

2. The Commissioner finds that the member is in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27; or

3. The Commissioner finds that fulfillment of the obligation(s) from which relief is sought would place the member in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27.

(c) Any waiver or deferral from a particular obligation granted by the Commissioner pursuant to this subchapter shall be for a specified period as set forth in the notice granting the request, but shall not exceed 12 months from the date of the notice. Any member seeking to continue a waiver or deferral shall file a separate request for relief in accordance with this subchapter no later than 45 days prior to the expiration of the waiver or deferral period set forth in the original notification granting the request. Such a request shall also include a detailed explanation of all actions the applicant has taken and intends to take to cure the financial impairment. Failure to file a properly completed request for relief within the time prescribed shall result in the expiration of the waiver or deferral at the expiration of the period set forth in the original notification granting the request. Nothing herein shall be construed as limiting or prohibiting any member from applying for relief at any time in accordance with this subchapter.

(d) If the Commissioner grants a request for a deferral of payment of an assessment, the terms of the deferral shall include the requirement that the member shall pay to the Board an additional amount representing the loss to the Board of the time value of the assessment for the period of the deferral.

1. In calculating the additional amount to be paid, the member shall use the annual interest rate on one-year U.S. Treasury bills as of the date the assessment was due and payable.

2. In calculating the additional amount to be paid, the period of deferral shall begin on the date that payment of the assessment was due and payable and end on the date of the amount deferred is paid to the Board.

3. The payment of the additional amount set forth in (d) above shall be in lieu of payment by the member of any interest or penalty on the amount deferred, which otherwise may be required under any other rule.

4. The requirement to pay an additional amount as provided in (d) above shall not apply when the reason for granting the deferral is that the member is in rehabilitation or conservation.

11:21–15.7 Hearings

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

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

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

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

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

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

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

i. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

11:21–15.8 Notice of the SEH Program

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

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

(a) Any member HMO asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it reasonably anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, pursuant to N.J.S.A. 17B:27A–26a, shall file the following information with the Commissioner:

1. A cover letter stating:

i. The name of the member HMO;

ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member; and

iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A–26a.

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

11:21–15.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations, medical service corporations, hospital service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation, medical service corporation, hospital service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32–31 et seq.

11:21–15.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the Board pursuant to N.J.S.A. 17B:27A–17 et seq. and the SEH Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

SUBCHAPTER 16. WITHDRAWALS OF SMALL EMPLOYER CARRIERS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET

Authority

N.J.S.A. 17:1C–6(e) and 17B:27A–23.

Source and Effective Date

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

11:21–16.1 Purpose and scope

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

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

11:21–16.2 Definitions

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

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

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

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

"State" means the State of New Jersey.

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

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

11:21–16.3 General provisions

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

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

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

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

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

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

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

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

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

4. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing;

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal;

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

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

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

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

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

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

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

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

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

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

11:21–16.4 Restrictions on writings

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

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

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

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

11:21–16.5 Penalties

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

11:21–16.6 Other policyholder rights unaffected

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

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

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

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

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

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

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

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

SUBCHAPTER 17. FAIR MARKETING STANDARDS

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).

11:21–17.1 Plan identification and marketing materials

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

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

(c) Small employer carriers shall not disseminate marketing and/or promotional material specific to the health benefits plans defined at N.J.A.C. 11:21–3 to policyholders or small employers until N.J.A.C. 11:21–3 is effective pursuant to the requirements of P.L. 1993, c.162, Section 16.

11:21–17.2 Retention of marketing and promotional materials

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

11:21–17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix, incorporated herein by reference, shall be signed by a duly authorized officer of the small employer carrier. Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general, or by February 15, 1994, whichever date is later.

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis following the filing of its initial certification.

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

11:21–17.4 Buyers' Guide

Small employer carriers shall set forth in their promotional and/or marketing materials that a Small Employer Health Benefits Buyers' Guide is available and can be obtained upon request, free of charge, by a small employer from the small employer carrier. Small employer carriers shall provide or mail a Buyers' Guide to small employers within three business days of request. A small employer carrier may arrange for delivery or distribution of the Buyers' Guide through its licensed agents or brokers.

11:21–17.5 Producer contracts

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

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

SUBCHAPTER 18. PETITIONS FOR RULES

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).

11:21–18.1 Scope

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

11:21–18.2 Procedure for petitioner

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

1. Name and address of the petitioner;

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

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

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

(b) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the

particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

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

11:21-18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21-18.2 the Board shall file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

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

3. The problem or purpose which is the subject of the request; and

4. The date the petition was received.

(b) Within 30 days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;

3. Certification by the Board that the petition was duly considered pursuant to law;

4. The nature or substance of the Board's action upon the petition; and

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

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

1. Denying the petition;

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

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

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
CN 325
Trenton, New Jersey 08625

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

PLAN A

[Carrier]

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER

[G–12345]

GOVERNING JURISDICTION

NEW JERSEY

EFFECTIVE DATE OF POLICY

[January 1, 1994]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

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.]

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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 Co–Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare** as Secondary Payor, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment

—per day	$250
—maximum Co–Payment per Period of Confinement	$1,250
—maximum Co–Payment per Covered Person per Calendar Year	$2,500

Co–Insurance

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

The **Co–Insurance** 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%
Co–Insurance 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 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.

• 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

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

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE: PLAN A PPO**

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co–Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment	
—per day	$250
—maximum Co–Payment per Period of Confinement	$1,250
—maximum Co–Payment per Covered Person per Calendar Year	$2,500

Co–Insurance

Co–Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co–Insurance requirement once Coinsured Charge Limit has been reached. This Policy's Co–Insurance, 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 **Co–Insurance** 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 Co–Insurance 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.

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

[Carrier] will cover the lessor 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

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 Co–Insurance)	
—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 children	$9999.99
—per Employee, spouse and children	$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 about 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.] One 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 or 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 another 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

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the

Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization 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 not 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 cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. 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.
b. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
c. with respect to Contributory Policies, 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; or
   2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

d. with respect to Non-contributory Policies, 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; or
   2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

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. All periods of insurance hereunder will begin and end at 12:00:01 a.m. 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 any Policy Anniversary if the Policyholder is no longer a Small Employer in accordance with the laws in the State of New Jersey.

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 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:

(1) to whom [Carrier] pays benefits,
(2) any protection and rights when the coverage ends and
(3) 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 statutes 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 wrong 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:

- agrees to participate in the trust, and
- 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 its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; 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 Co–Insurance, Co–Payments and Non–Covered Charges. See the **The Cash Deductible** section of this Policy for details.

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–Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

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.

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 students 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 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. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Coverage Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion 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 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].

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 and 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 in 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.

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). 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, 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 (C. 39:6A–1 et seq.).

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. A Mental and Nervous Condition is not an Illness.

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 due to accident, 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.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

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** sections 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.

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 and 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 and 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 and 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.

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 registered at a recognized health care Facility who is not an Inpatient.

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 this group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recom-

mended by a Practitioner in the six months before his or her coverage starts; or

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

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

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 stain, 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 any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% 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, all Affiliated Companies will be considered as one Employer.

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.

[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.

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

[Carrier] will not insure an Employee unless the Employee is an Actively at Work 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.

However, 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. 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 he or she becomes eligible.

[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 set the rates, determine class, figure benefit amounts, 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

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, [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.

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 Full–Time Employee for any reason. Such reasons include disability, 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.

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. on active duty in any armed forces of any country; or
b. insured 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, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or

c. 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.

However, 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;
b. divorce;
c. death of the Employee's spouse; or
d. 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 one of the above events 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.

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 the exception stated below and 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 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.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

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.
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.

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.

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 a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. ***Network Benefits*** means 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 Co–Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co–Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out–Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out–Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

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 Co–Payments 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.]

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 Co–Insurance or Co–Payments, 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 Co–Insurance or Co–Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

[Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co–Insurance is required.]

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness 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 insurer.

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 starts right after the old plan ends.

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 starts right after the old plan ends.

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 the same way [Carrier] covers charges for any Illness.

[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 Co–Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co–Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co–Payment 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:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
      - 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.

c. 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 very 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [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.

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 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.

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre–Existing Conditions" 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 sections to determine if a Covered Person 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 if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre–Existing Conditions

A Pre–Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre–Existing Condition.

[Carrier] does not pay benefits for charges for Pre–Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre–Existing Condition if the condition was payable under another [Carrier] group plan 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

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre–Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full–Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And 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 previous plan ends and the date his or her coverage under this Policy starts 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 of 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.

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 and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person $300 per Covered Family.

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, Co–Payment and Co–Insurance 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 an 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 admis-

sion. 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 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 outcome 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. Co–Insurance Caps.]

[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 Co–Insurance.

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. Co–Insurance Caps.]

[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 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 or 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, unless it is required as a result of an Illness or Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

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.

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 lense; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (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.

Care and or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

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.***

Care or treatment by means of ***high dose chemotherapy.***

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit 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 and 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.

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.

Non-prescription drugs or supplies, except insulin needles and syringes.

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). 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;

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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.

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. Any person who becomes covered under this Policy during a continuation provided by this section is not 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, he or she 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.

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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 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. 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 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 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 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.

AN 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:

- the Employer must allow for a leave of absence under Federal law in which case;
- 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:

- an HMO waiting period
- an HMO Pre–Existing conditions limit, or
- 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:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre–Existing Conditions limit expires, or

- 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:

- **an HMO ends its operations**
- **Employee moves outside 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:

- on or before the date membership ends, they will be insured on the date such membership ends
- 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, 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:

- 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, 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:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre–Existing Conditions provisions.

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 expense 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; 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;
d. Supplemental Limited Benefits Insurance; nor
e. 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. 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 if 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 member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this 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 divorced 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 person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays 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 gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has 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.

BENEFIT 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 Co–Payments, if any or Co–Insurance.

"Out–of–State Automobile Insurance Coverage" or "OSAIC" means any overage 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 have 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:

- the Covered Person is insured under more than one insurance plan; and
- 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 Co–Payments, 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 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 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, Medicare is the primary plan. This Policy 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 an "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 18 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 18 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 an 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 18 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part 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 contract the nearest Area Office of the U.S. Labor–Management Services Administration, Department of Labor.

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 an 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).

EXHIBIT B

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	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor**, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment	
—per day	$200
—maximum Co–Payment per Period of Confinement	$1,000
—maximum Co–Payment per Covered Person per Calendar Year	$2,000
—**Emergency Room Co–Payment,** (waived if admitted within 24 hours)	$50

Co–Insurance

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

The **Co–Insurance** for this Policy is as follows:	40%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:

- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments.

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.

• 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

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 Co–Insurance)	
• 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 for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

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DEFINITIONS **[PLAN B]**

. . .

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"].

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

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HEALTH BENEFITS INSURANCE [PLAN B]

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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.

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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co–Payment Requirement section.

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.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Hospital Co–Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co–Payment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Co–Payment per Calendar Year.

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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.

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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).

EXHIBIT C

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLANS C, D, 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

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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor**, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

The **Co–Insurance** for this Policy is as follows:	30%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:

- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments.

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.

- **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

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 Co–Insurance)	
• 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 for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

. . .

DEFINITIONS **[PLANS C, D, E]**

. . .

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"]

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

. . .

HEALTH BENEFITS INSURANCE [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 this Policy. Read the entire Policy 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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co–Payment Requirement section.

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.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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.

. . .

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).

EXHIBIT D

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

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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor**, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment,
(waived if admitted within 24 hours) $50

Co–Insurance

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

The **Co–Insurance** for this Policy is as follows:	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:

- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments.

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.

- 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

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 (Not subject to Cash Deductible or Co–Insurance)	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

. . .

DEFINITIONS **[PLANS C, D, E]**

. . .

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"]

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

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

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

...

HEALTH BENEFITS INSURANCE [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 this Policy. Read the entire Policy 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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co–Payment Requirement section.

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.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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.

...

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).

EXHIBIT E

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

Per Covered Person	$150
Per Covered Family	$300. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment,
(waived if admitted within 24 hours) $50

Co–Insurance

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

The **Co–Insurance** for this Policy is as follows:	10%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:

- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments

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.

- 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

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 (Not subject to Cash Deductible or Co–Insurance)	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

. . .

DEFINITIONS [PLANS C, D, E]

. . .

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"]

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

. . .

HEALTH BENEFITS INSURANCE [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 this Policy. Read the entire Policy 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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co–Payment Requirement section.

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.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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.

. . .

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).

EXHIBIT F

PLANS B, C, D, E

[Carrier]

SMALL GROUP HEALTH BENEFITS POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER

[G–12345]

GOVERNING JURISDICTION

NEW JERSEY

EFFECTIVE DATE OF POLICY

[January 1, 1994]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

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)
Schedule of Insurance and Premium Rates	
General Provisions	
Claim Provisions	
Planholders	
Definitions	
Employee Coverage	
Dependent Coverage	
Preferred Provider Organization Provisions	
Point of Service Provisions	
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	

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (without Co-payment)**

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	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment	
—per day	$200
—maximum Co–Payment per Period of Confinement	$1,000
—maximum Co–Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

The **Co–Insurance** 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 Co–Insurance is required, **except as stated below.**

Exception: Charges for Mental and 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 (with Co-payment)**

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

Co–Payment—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

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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours) (Out–Network Provider) $50

Co–Insurance

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

The **Co–Insurance** 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 Co–Insurance is required, **except as stated below.**

Exception: Charges for Mental and 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 POS**

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

Co–Payment—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	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours) (Out–Network Provider)	$50

Co–Insurance

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

The **Co–Insurance** for this Policy is as follows:	
• if treatment, services or supplies are given by the PCP	None, except as stated below
• if treatment, services or supplies are given or referred by a non-referred Provider	20%, except as stated below
Exception: for Mental and Nervous and Substance Abuse charges	
• if treatment, services or supplies are given or referred by the PCP	5%
• 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 Co–Insurance is required, **except as stated below.**

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

Coinsured Charge Limit:	$10,000

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 children	$9999.99
—per Employee, spouse and children	$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 about 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]. One 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 as 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 or 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

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization 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 not 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 cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. 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.
b. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
c. with respect to Contributory Policies, 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; or
   2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

d. with respect to Non-contributory Policies, 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; or
   2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Policy is issued for a term of one (1) year from the Effective Date shown in the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. 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 any Policy Anniversary if the Policyholder is no longer a Small Employer in accordance with the laws in the State of New Jersey.

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 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:

(1) to whom [Carrier] pays benefits,
(2) any protection and rights when the coverage ends and
(3) 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 statutes 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 wrong 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:

- agrees to participate in the trust, and
- 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 its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; 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 Co–Insurance, Co–Payments and Non–Covered Charges. See the **The Cash Deductible** section of this Policy for details.

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–Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Coverage 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 or he or she is insured by this Policy. Read the 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.

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 students 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 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. EKG's, EEG's 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 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 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].

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 and 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.

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). 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, 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 (C. 39:6A–1 et seq.).

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.

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 any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% 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, all Affiliated Companies will be considered as one Employer.

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 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.

[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.

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

[Carrier] will not insure an Employee unless the Employee is an Actively at Work 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.

However, 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. 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 he or she becomes eligible.

[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 set the rates, determine class, figure benefit amounts, 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

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, [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.

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 Full–Time Employee for any reason. Such reasons include disability, 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.

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 Employees:

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 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, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. 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.

However, 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;
b. divorce;
c. death of the Employee's spouse; or
d. 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 one of the above events 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.

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 the exception stated below and 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 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.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

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.
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.

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.

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 a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

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*** means 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 uses 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 Co–Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co–Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out–Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out–Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

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 Co–Payments 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 offered as POS.]

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 limited 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 Co–Insurance or Co–Payments, 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 Co–Insurance or Co–Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

Coinsured Charge Limit

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

Exception: Charges for Mental and 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 Illness 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 two 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 insurer.

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 starts right after the old plan ends.

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 starts right after the old plan ends.

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.

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 and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

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 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 this Policy and to the following conditions:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
      - 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.

c. 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 very 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [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 and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

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 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.

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.

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.

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 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 and 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 and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and 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" 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 COV-

ERAGE sections to determine if a Covered Person 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 if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre–Existing Conditions

A Pre–Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre–Existing Condition.

[Carrier] does not pay benefits for charges for Pre–Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre–Existing Condition if the condition was payable under another [Carrier] group plan 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

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre–Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full–Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And 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 previous plan ends and the date his or her coverage under this Policy starts 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 of 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.**

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 and screening tests. 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 changes are not subject to the Cash Deductibles or Co–Insurance.

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.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and 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 and Nervous conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Co–Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

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 High Dose 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 connecting with such treatment of breast cancer which are not Pre–Approved by [Carrier] are Non–Covered Charges.*

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, Co–Payment and Co–Insurance 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 an 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 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 outcome 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. Co–Insurance Caps.]

[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 Co–Insurance.

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. Co–Insurance Caps.]

[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 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 [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, unless it is required as a result of an Illness or Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

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.

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.

Care and/or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

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.***

Care or treatment by means of ***high dose chemotherapy,*** except as otherwise stated in this Policy.

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit 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.***

Supplies related to ***Methadone*** maintenance.

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.

Non-prescription drugs or supplies, except insulin needles and syringes.

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; 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). 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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 CONTINUING 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. Any person who becomes covered under this Policy during a continuation provided by this section is not 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, he or she 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.

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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 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. 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 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 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 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 benefits plan 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.

AN 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:

- **the Employer must allow for a leave of absence under Federal law in which case;**
- **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:

- an HMO waiting period
- an HMO Pre–Existing Conditions limit, or
- 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:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre–Existing Conditions limit expires, or
- 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:

- **an HMO ends its operations**
- **Employee moves outside 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:

- on or before the date membership ends, they will be insured on the date such membership ends
- 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, 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:

- 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, 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:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre–Existing Conditions provisions.

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; 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;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] 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. 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 if 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 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 person 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 Co–Payments, if any or Co–Insurance.

"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 have 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:

- the Covered Person is insured under more than one insurance plan; and
- 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 SAIC has provided coverage after applying Cash Deductibles and Co–Payments, 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 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 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, Medicare is the primary plan. This Policy 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 18 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 18 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 an 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 18 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part 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 Employees' 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 Area Office of the U.S. Labor–Management Services Administration, Department of Labor.

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 an 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 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).

EXHIBIT G

HMO PLAN

[Carrier]

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, 1994]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier], in consideration of the application for this Contract and of 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]

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I. SCHEDULE OF PREMIUM RATES

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

Subscriber and Child(ren) .....$
Subscriber and Family .....$
(including Subscriber, spouse and one or more eligible dependents)]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Contract entitled "Contract Holder General Provisions."

II. SCHEDULE OF SERVICES

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]:

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

DOCTOR SERVICES RECEIVED AT A HOSPITAL:

INPATIENT

None

OUTPATIENT

$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM

$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)

OUTPATIENT SURGERY

$15 Copayment/visit.

HOME HEALTH CARE

Unlimited days, if preapproved.

HOSPICE SERVICES

Unlimited days, if preapproved.

MATERNITY (PRE–NATAL CARE)

$25 Copayment for initial visit only.

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.

PODIATRIC

$15 Copayment/visit (excludes Routine Foot Care).

PRE–ADMISSION TESTING

$15 Copayment/visit.

PRESCRIPTION DRUG

50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES

$15 Copayment/visit.

PRIMARY CARE SERVICES

$15 Copayment/visit.

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.

THERAPY SERVICES

$15 Copayment/visit.

DIAGNOSTIC SERVICES (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 PRI-

MARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

III. 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 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 of 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.

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 Contract Holder through common ownership of stock or assets.

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.]

[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 Employer and [Carrier].

CONTRACT HOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies.

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.

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.

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 insured 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. Our sole right to make a decision or determination.

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 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].

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 and 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.

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.

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). 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, 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 (C. 39:6A–1 et seq.).

[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.]

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. A Mental or Nervous Condition is not an illness.

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 due to accident, 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 Facilities.

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** sections 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 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 Subscriber/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 and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personally 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 and 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 registered at a Practitioner's office 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 Determine if the cause(s) of the confinements are the same or related.

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. An Illness or Injury which manifests itself in the six months before a Member's coverage under this Contract starts, and for which:

a. a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also 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.

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.

REASONABLE and CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary 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. Specific direction or instruction from A Member's Primary Care Physician 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 Facilities; or
b. be approved for its stated purpose by Medicare.

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 defined 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. Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% 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, all Affiliated Companies will be considered as one Employer.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

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)].

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

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; or
c. pre-operative and post-operative care.

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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.

IV. 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 Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full–Time Employees.

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

[Carrier] will not cover an Employee unless the Employee is an Actively at work 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.

However, if an Employee initially waived coverage under his 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. 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 he or she becomes eligible.

[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 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.]

Multiple Employment

If an Employee works for both the Contract Holder 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.

When Employee Coverage Starts

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, [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 scheduled Effective Date of an Employee's coverage.

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 Full–Time Employee for any reason. Such reasons include disability, 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.

e. [the date] an Employee moves his or her permanent residence outside the Service Area.

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 defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

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.

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.

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; and
b. 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 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. [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, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. 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.

However, 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;
b. divorce;
c. death of the Employee's spouse; or
d. 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 one of the above events occurs.

And, [Carrier] 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.

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 the exception stated below and 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 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 is first eligible.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

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.]
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 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.

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:

(1) **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.
(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use an identification card We issue to the Member.

(3) **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 section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.

(5) **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.

(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits 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** (2 above) or **Misconduct** (5 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 Grievance Procedures We establish.

V. COVERED SERVICES AND SUPPLIES

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 co-insurance] as stated in the applicable Schedule of Services.

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:

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. **Infertility Services** 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 insulin syringes and insulin needles** when obtained through a Participating Provider.

b. **SPECIALIST DOCTOR BENEFITS.** The following 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. Services include but are not limited to the following:

1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
2. Anesthesia
3. Cardiology
4. Endocrinology
[5. Gynecology and Obstetrics]
6. Internal Medicine
7. Neurology
8. Oncology
9. Ophthalmology
10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
11. Orthopedics
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Podiatry

16. Pulmonology
17. Radiology (except dental x-rays, unless related to Covered Services)
18. Surgery
19. Urology

c. **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER AND 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
2. Private accommodations. 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 the 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
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 high dose 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.

d. **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND 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.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician 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.

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.

3. 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.

e. **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered 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] 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. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   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 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 Nonparticipating 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 Nonparticipating 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 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 Member 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.

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 and Radiation Therapy.

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.

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 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.

VI. 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, unless it is required as a result of an Illness or Injury sustained while covered under this Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

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.

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 astigmation (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.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafalopian-transfer (GIFT); surrogate motherhood.

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.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Contract.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit 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.

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 insulin needles and insulin syringes.

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: We do not cover services for Pre–Existing Conditions until Members have been covered by this Contract for six months. See the "Definitions" section of this Contract for the definition of a Pre–Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for a Member's Pre–Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Contract started, i.e., there is no intervening lapse in coverage.]

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 a **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.**

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). 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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.

VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VIII. COORDINATION OF BENEFITS AND SERVICES 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 [Carrier] is 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;
d. Supplemental Limited Benefits Insurance coverages; nor
e. 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. 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 if 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 first or provides services, ignoring all other plans. The secondary plans then 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 divorced parents, the following governs which plan pays 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 plans 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 person 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 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" means that of service provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co–Payments, if any or Co–Insurance.

"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 Contract Holder'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:

- the Member is insured or covered for services under more than one insurance plan; and
- 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 Co–Payments, or
b. the equivalent value of services if this Contract had been primary.

IX. CONTRACT HOLDER GENERAL PROVISIONS

AMENDMENTS

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 Contract Holder 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 Contract Holder, 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 Contract Holder, as evidenced by payment of a Premium on or after the effective date of such change.
d. if a written request for a change is made by the Contract Holder, it is shown in an amendment to it signed by the Contract Holder and by one of Our Officers.

ASSIGNMENT

No assignment or transfer by the Contract Holder of any of the Contract Holder's interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

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

CONFORMITY WITH LAW

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes 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.

[CONVERSION PRIVILEGE

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

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 Contract Holder 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.

If this Contract replaces the contract of another insurer or carrier, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

NOTICES AND OTHER INFORMATION

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

If to Us: To Our last address on record.

If to the Contract Holder: To the last address provided by the Contract Holder 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 Contract Holder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplication of it is attached to this Contract or has been furnished to the Contract Holder for attachment to this Contract.

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 then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Contract Holder 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 Contract Holder 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 Contract Holder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contract Holder 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 Contract Holder 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.

TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE

We have the right to cancel this Contract on any premium due date subject to 30 days advance written notice to the Contract Holder for the following reasons:

a. During or 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 Contract Holder 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.

b. the Contract Holder moves its principal place of business outside the State of New Jersey;

c. subject to the statutory notification requirements, We cease to do business in the small group market;

d. with respect to Contributory Contracts, 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; or

2. the Employee is covered under an alternate benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e. with respect to Non-contributory Contracts, 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; or

2. the Employee is covered under an alternate health benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Contract Holder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

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. All periods of coverage hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Contract Holder's place of business.

The Contract Holder 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 any Contract Anniversary if the Contract Holder is no longer a Small Employer.

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 Contract Holder'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.

X. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Contract is valid unless We consent thereto.

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 by 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.

CONVERSION PRIVILEGE

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

GOVERNING LAW

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

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the 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 Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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 Contract Holder 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.

If this Contract replaces the contract of another insurer or carrier, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. 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.
2. Neither the Contract Holder 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.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

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.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services 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.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity 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.

NOTICES AND OTHER INFORMATION

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

If to Us: To Our last address on record.

If to 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 Member'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 mailed to a Member for attachment to this Contract.

CONTRACT INTERPRETATION

We shall administer Contracts in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

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

Member will be responsible for the cost of all 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.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to 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, Subscriber, 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.

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 from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. 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.

[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.]

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 DEPENDENT COVERAGE

If an Employee fails to pay the cost of Dependent coverage, an Employee's Dependent coverage will end. It will end on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he attains the Contract's age limit, or marries, or when a step-child is no longer dependent on the Employee for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

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

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

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 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 and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage 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.]

XI. 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.

When covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subjected 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, and therefore;
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. Any person who becomes covered under this Contract during a continuation provided by this section is not 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 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, he or she 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 the **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.

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; 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 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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 an insured 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 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 covered Dependents whose coverage would otherwise end at this time. 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 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 for 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:

- the Employer must allow for a leave of absence under Federal law and, therefore
- 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, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

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. 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 benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been covered under this Contract for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be excessively covered; or

[• if he or she permanently relocates outside the Service Area.]

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.

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 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.

XII. 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 pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part 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.

XIII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

1. In the case of an Employee, the Employee is not retired.
2. In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.
3. The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.

For a member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

1. The Member, if eligible, has enrolled in Parts A and B of Medicare.
2. The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES.

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

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).

EXHIBIT H

PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD/MAIL)**
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 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:
   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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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 or Mental and Nervous Conditions and Substance Abuse;

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 containing nicotine or other smoking deterrent medication.
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).

EXHIBIT H

PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)
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 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:
   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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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 of 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 or Mental and Nervous Conditions and Substance Abuse

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 containing nicotine or other smoking deterrent medication.
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).

EXHIBIT H

PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE **(MAIL)**
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 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:

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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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:

SECTION	PAGE(S)
• 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 or Mental and Nervous Conditions and Substance Abuse

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 containing nicotine or other smoking deterrent medication.
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).

EXHIBIT I

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, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse 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 and 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 precertifies 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. 30 days of Inpatient care per Calendar year; and
b. 20 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).

EXHIBIT J
PART 1
RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No:

Effective Date:

The Prescription Drug section of the Covered Services and Supplies Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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 Drugs from a Participating Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of the following chronic medical conditions.

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 or Mental or Nervous Condition.

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 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, except as stated in the Extended Health Benefit section of the Contract.

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.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
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 for which there is no charge. This usually means 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 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]

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).

EXHIBIT J

PART 2

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or

3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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 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 or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than 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.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

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 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]

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).

EXHIBIT J

PART 3

RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**
Contract Holder:
Group Contract No:
Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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 Drugs from a Participating Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of the following chronic medical conditions.

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 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 or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance 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.

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.
k. Vitamins, except for Legend Drug vitamins.

Pre–Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

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 Co–Insurance)	
—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.] One 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 statutes 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 its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; 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 Co–Insurance, Co–Payments and Non–Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

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–Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

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.

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 students 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 purposes 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. EKG's, EEG's 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 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 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].

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 and 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.

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). 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, 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 (C. 39:6A–1 et seq.).

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. A Mental and Nervous Condition is not an Illness.

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 due to accident, 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.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

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** sections 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.

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 and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods of psychotropic medication, regardless of any underlying physical cause. A Mental and 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 and 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.

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 registered at a recognized health care Facility who is not an Inpatient.

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"]

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

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

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

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 any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% 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, all Affiliated Companies will be considered as one Employer.

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 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.

[**We, Us, Our** and **[Carrier]** mean [Carrier].]

[**You, Your and Yours** mean an Employee who is insured under the Policy.]

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.

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

[Carrier] will not insure an Employee unless the Employee is an Actively at Work 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.

However, 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. 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 he or she becomes eligible.

[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 date 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

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, [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.

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 Full–Time Employee for any reason. Such reasons include disability, 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.

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. [Carrier] considers 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, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or
c. 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.

However, 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;
b. divorce;
c. death of Your spouse; or
d. 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 one of the above events 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.

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 the exception stated below and 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 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.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

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.
b. If You are not covered for Dependent child coverage on the date the child is born, then 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.

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 a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

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 uses 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 Co–Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co–Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out–Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out–Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

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 Co–Payments 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.]

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 Co–Insurance or Co–Payments, 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 Co–Insurance or Co–Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

[Coinsured Charge Limit

The coinsured charge limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co–Insurance is required.]

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness 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 the Policy may have purchased it to replace a plan the Employer had with some other insurer.

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 starts right after the old plan ends.

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 starts right after the old plan ends.

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 the same way [Carrier] covers charges for any Illness.

[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 Co–Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co–Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co–Payment 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:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

b. The services and supplies must be:

- 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.

c. 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.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [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.

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.

Hospital 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.

Hospital 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 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.

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre–Existing Conditions" 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** sections to determine if a Covered Person 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 if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre–Existing Conditions

A Pre–Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre–Existing Condition.

[Carrier] does not pay benefits for charges for Pre–Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre–Existing Condition if the condition was payable under another [Carrier] group plan 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

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre–Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full–Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And 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 previous plan ends and the date his or her coverage under the Policy starts 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 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.

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 and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, $300 per Covered Family.

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, Co–Payment and Co–Insurance 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 an 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 their review. And [ABC] confirms the outcome 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. Co–Insurance Caps.]

[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 Co–Insurance.

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; or
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or
b. Co–Insurance Caps.]

[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 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 [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, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

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.

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.

Care and/or treatment to enhance *fertility* using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

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.*

Care or treatment by means of *high dose chemotherapy.*

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit 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 and 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.

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.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed *pastoral counselor* in the course of his or the 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; 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 the Policy.

Services or supplies:

a. eligible for payment under either Federal or state programs (except Medicaid). 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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.

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. Any person who becomes covered under the Policy during a continuation provided by this section is not 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, You may elect to extend Your 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 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 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.

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 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 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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 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. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

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 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 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 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.

AN 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:

- Your Employer must allow for a leave of absence under Federal law in which case;
- 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:

- an HMO waiting period
- an HMO Pre–Existing Conditions limit, or
- 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:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre–Existing Conditions limit expires, or
- 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:
- an HMO ends its operations
- Employee moves outside 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:

- on or before the date membership ends, they will be insured on the date such membership ends
- 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 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 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:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre–Existing Conditions provisions.

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 an 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;
d. Supplemental Limited Benefits Insurance; nor
e. 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. 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 if 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 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 divorced 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 person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays 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 gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has 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 Co–Payments, if any or Co–Insurance.

"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:

- the covered Person is insured under more than one insurance plan; and
- 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 Co–Payments, 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, Medicare is the primary plan. The Policy 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 18 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 18 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 18 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part 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 Employees' 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 Area Office of the U.S. Labor–Management Services Administration, Department of Labor.

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 an 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).

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:	01–01–94
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.]

CERTIFICATE INDEX

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SCHEDULE OF INSURANCE	**[PLAN B]**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS SCHEDULE OF INSURANCE [PLAN B]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment	
—per day	$200
—maximum Co–Payment per Period of Confinement	$1,000
—maximum Co–Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

The Co–Insurance for the Policy is as follows:	40%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:
- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments.

SCHEDULE OF INSURANCE [PLAN C]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:
- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments.

SCHEDULE OF INSURANCE [PLAN D]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

The Co–Insurance for the Policy is as follows:	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:
- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments

SCHEDULE OF INSURANCE [PLAN E]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible	
Per Covered Person	$150
Per Covered Family	$300, **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours)	$50

Co–Insurance

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

The Co–Insurance for the Policy is as follows:	10%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%
Co–Insurance 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

Note: The Co–Insurance Caps cannot be met with:
- Non–Covered Charges
- Cash Deductibles
- Co–Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co–Payments

SCHEDULE OF INSURANCE EXAMPLE PPO (without Co–Payment)

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the

Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co–Payment
—per day $200
—maximum Co–Payment per Period of Confinement $1,000
—maximum Co–Payment per Covered Person per Calendar Year $2,000

Emergency Room Co–Payment, (waived if admitted within 24 hours) $50

Co–Insurance

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

The **Co–Insurance** 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 Co–Insurance is required, **except as stated below.**

Exception: Charges for Mental and 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 **EXAMPLE PPO (with Co–Payment)**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co–Payment—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
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours) (Out–Network Provider) $50

Co–Insurance

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

The **Co–Insurance** 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 Co–Insurance is required, **except as stated below.**

Exception: Charges for Mental and 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 **EXAMPLE POS**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co–Payment—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	
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

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co–Payment, (waived if admitted within 24 hours) (Out–Network Provider) $50

Co–Insurance

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

The **Co–Insurance** for the Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, except as stated below
• if treatment, services or supplies are given or referred by a non-referred Provider	20%, except as stated below
Exception: for Mental and Nervous and Substance Abuse charges	
• if treatment, services or supplies are given or referred by the PCP	5%
• 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 Co–Insurance is required, **except as stated below.**

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

Coinsured Charge Limit: $10,000

[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.

- **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

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 Co–Insurance)	
• 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 for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

[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.

- **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

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 Co–Insurance)	
• 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 for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

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.] One 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 statutes 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 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 its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; 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 Co–Insurance, Co–Payments and Non–Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

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–Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

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.

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 students 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 purposes 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. EKG's, EEG's 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 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 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].

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 and 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 nonaffiliated authoritative resources, 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 in 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.

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). 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, 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 (C. 39:6A–1 et seq.).

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. A Mental and Nervous Condition is not an Illness.

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 due to accident, 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.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

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** sections 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.

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 and 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 and 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 and 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.

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 midwife 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.

[PLAN B]

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"].

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

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Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

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"].

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 means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also 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 and screening tests.

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 any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% 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, all Affiliated Companies will be considered as one Employer.

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.

[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.

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

[Carrier] will not insure an Employee unless the Employee is an Actively at Work 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.

However, 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. 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 he or she becomes eligible.

[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

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, [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.

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 Full-Time Employee for any reason. Such reasons include disability, 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.

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 stepchildren if such stepchildren 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 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, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or
c. 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.

However, 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;
b. divorce;
c. death of Your spouse; or
d. 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 one of the above events 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.

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 the **exception** stated below and 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 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.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

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.
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.

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 a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

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 uses 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 Co–Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co–Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out–Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by a [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out–Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

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 Co–Payments 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 POS.]

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 Co–Insurance or Co–Payments, 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 Co–Insurance or Co–Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

[Coinsured Charge Limit

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

Exception: Charges for Mental and 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 Illness 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 the Policy may have purchased it to replace a plan the Employer had with some other insurer.

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 starts right after the old plan ends.

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 starts right after the old plan ends.

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.

[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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[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 Co–Payment 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 noncompliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Hospital Co–Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co–Payment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Co–Payment per Calendar Year.

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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.

[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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[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 Co–Payment 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 and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Emergency Room Co–Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co–Payment, 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 and 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.

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:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
   - 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.
   c. 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.
   d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   e. [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 and 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.

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.

Hospital 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 postpartum 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 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.

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-rays and tests done as part of routine physical checkups.

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury 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 and 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 and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and 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 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 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" 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** sections to determine if a Covered Person 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 if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre–Existing Conditions

A Pre–Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre–Existing Condition.

[Carrier] does not pay benefits for charges for Pre–Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre–Existing Condition if the condition was payable under another [Carrier] group plan 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

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre–Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full–Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And 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 previous plan ends and the date his or her coverage under the Policy starts 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.**

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 and screening tests. 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 Co–Insurance.

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.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and 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 and Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Co–Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

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. Allogenic 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 [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.**

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, Co–Payment and Co–Insurance 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 an 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 outpatient 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'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 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 outcome 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. Co–Insurance Caps.]

[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 Co–Insurance.

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; or
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or
b. Co–Insurance Caps.]

[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 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 [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, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

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.

Care and/or treatment to enhance *fertility* using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

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.*

Care or treatment by means of *high dose chemotherapy,* except as otherwise stated in the Policy.

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit 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.*

Supplies related to *Methadone* maintenance.

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.

Non-prescription drugs or supplies, except insulin needles and syringes.

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.*

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). 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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. Any person who becomes covered under the Policy during a continuation provided by this section is not 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, You may elect to extend Your 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 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 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.

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 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 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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 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. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

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 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 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 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.

AN 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:

- Your Employer must allow for a leave of absence under Federal law in which case;
- 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:

- an HMO waiting period
- an HMO Pre–Existing Conditions limit, or
- 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:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre–Existing Conditions limit expires, or
- 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.

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:

- on or before the date membership ends, they will be insured on the date such membership ends
- 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 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 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:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre–Existing Conditions provisions.

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; 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;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] 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. 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 if 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 member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this 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 divorced 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 person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] applies 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 gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has 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 Co–Payments, if any or Co–Insurance.

"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:

- the covered Person is insured under more than one insurance plan; and
- 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 SAIC has provided coverage after applying Cash Deductibles and Co–Payments, 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, Medicare is the primary plan. The Policy 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 18 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 18 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 an 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 18 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. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

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 pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part 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 Employees' 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 Area Office of the U.S. Labor–Management Services Administration, Department of Labor.

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 an 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).

EXHIBIT X

PART 1

EXPLANATION OF BRACKETS—CERTIFICATE FORMS

(PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].
2. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
3. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
4. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

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 the certificate forms.

1. 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 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.
2. 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 policy.
3. Variable amounts appearing in the Schedule of Insurance may be included on the Schedule, or specified on the face page, sticker, or separate schedule, as discussed above.
4. The Payment of Premiums—Grace Period section of the General Provisions may be omitted from the certificate, at the option of the Carrier.
5. Dividend text which appears both on the Face Page and in the General Provisions should only be included by Carriers that could pay dividends. At the option of the carrier, such text may be omitted from the certificate.
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 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.
9. The Definition of "You, Your and Yours" may be omitted. If omitted, references throughout the text to You, Your and Yours should be replaced with Employee terminology.
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.
11. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
12. 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 Insurance for review and approval prior to use, as specified in regulation.
13. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.
14. 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.

(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.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).

EXHIBIT X

PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], 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.

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 Evidence of Coverage forms.

1. The face page text may be modified to be consistent with a Carrier's methods of Evidence of Coverage personalization. The data reflected on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the document. Carriers may also elect to use a no-name Evidence of Coverage.
2. The term "Evidence of Coverage" may be replaced with another similar term to adapt to a carrier's typical practice of providing employees with proof of coverage documents.
3. Co–Payments may be elected by the Employer, subject to the availability specified in regulation.
4. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.
5. The Pre–Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre–Existing Condition Exclusion.
6. OB/GYNs can be considered Primary Care Physicians.
7. Eligible class references can be removed.
8. 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.
9. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
10. Small Claims Waiver can be deleted.
11. Transfer of Primary Care Physician can occur according to Carrier administration.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(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 Contract Holder. 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.]

CONTRACT HOLDER: [ABC Company]
GROUP CONTRACT NUMBER: [G–12345]
[EMPLOYEE: [John Doe]]
[CERTIFICATE NUMBER: [C–123456]]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE: [January 1, 1994]
[COVERED CLASSES:
[All Employees of the Contract Holder (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]

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I. SCHEDULE OF SERVICES

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.

[SERVICES	COPAYMENTS[/COINSURANCE]:
	Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT DOCTOR SERVICES RECEIVED AT A HOSPITAL:	$15 Copayment/visit
INPATIENT	None
OUTPATIENT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)
OUTPATIENT SURGERY	$15 Copayment/visit.
HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE SERVICES	Unlimited days, if preapproved.
MATERNITY (PRE–NATAL CARE)	$25 Copayment for initial visit only.
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.
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE–ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
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.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES (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. READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS EVIDENCE OF COVERAGE CALLED "NON–COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

II. 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.]

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.

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

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.]

[**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].

CONTRACT HOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies.

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.

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

(a) is furnished mainly to help a Member meet his or her routine daily needs; or

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

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.

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. Our sole right to make a decision or determination.

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 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 ELIGIBILITY DATE.

a. the date of employment; or

b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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 and 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.

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.

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). 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, 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 (C. 39:6A-1 et seq.).

[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.]

GROUP HEALTH CARE PLAN. The plan of health care coverage described in this Evidence of Coverage which a Contract Holder 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.

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. A Mental and Nervous Condition is not an Illness.

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 due to accident, 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 Facilities.

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** sections 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 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 Subscriber/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 and 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 and 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 the Group Health Care Plan.

OUTPATIENT. Member if registered at a Practitioner's office 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 Determine if the cause(s) of the confinements are the same or related.

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 Group Health Care Plan.

[PRE–EXISTING CONDITION. An Illness or Injury or Mental or Nervous Condition which manifests itself in the six months before a Member's coverage under the Group Health Care Plan starts, and for which:

(a) a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre–Existing Condition.

See the Non–Covered Services and Supplies section for details on how the Group Health Care Plan 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.

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.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under the Group Health Care Plan. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician 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.

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.

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)].

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

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; or

(c) pre-operative and post-operative care.

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.

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

YOU, YOUR AND YOURS. The Employee.]

III. 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 Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full–Time Employees.

We will treat partners, proprietors and independent contractors like Employees if they meet the Group Health Care Plan's **Conditions of Eligibility.**

Conditions of Eligibility

Full–Time Requirement

[Carrier] will not cover You unless You are an Actively at Work 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 the Your Employee Eligibility Date.

If You enroll and agree to make the required payments, if any:

a. more than [30] days after the 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.

However, 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 to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. 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 You become eligible.

[**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.]

Multiple Employment

If You work for both the Contract Holder 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.

When Employee Coverage Starts

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, [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 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.

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 Full–Time Employee for any reason. Such reasons include disability, 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.
e. You move Your permanent residence outside the Service Area.

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

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.

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; and
b. 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 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. [Carrier] considers 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, other than the first newborn child, have other eligible Dependents who You have not elected to enroll; or

c. 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.

However, 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;

b. divorce;

c. death of Your spouse; or

d. 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 one of the above events occurs.

And, [Carrier] will not consider 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 a court order.

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 the exception stated below and 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 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, 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 will be covered from the later of:

a. the date You notify [Carrier], or
b. the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date Your Dependent health coverage would otherwise start, [Carrier] will postpone the Effective Date of such coverage until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

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.]
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. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

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 contracts.

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:

(1) **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.

(2) **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.

(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Group Health Care Plan. This condition is subject to the provisions of the section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Group Health Care Plan.

(5) **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.

(6) **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** (2 above) or **Misconduct** (5 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 Grievance Procedures We establish.

IV. COVERED SERVICES AND SUPPLIES

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 co-insurance] as stated in the applicable Schedule of Services.

(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:

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. **Infertility Services** except where specifically excluded in this Evidence of Coverage.
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 the 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 insulin syringes and insulin needles** when obtained through a Participating Provider.

(b) **SPECIALIST DOCTOR BENEFITS.** The following 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. Services include, but are not limited to, the following:

1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
2. Anesthesia
3. Cardiology
4. Endocrinology
[5. Gynecology and Obstetrics]
6. Internal Medicine
7. Neurology
8. Oncology
9. Ophthalmology
10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
11. Orthopedics
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Podiatry
16. Pulmonology
17. Radiology (except dental x-rays, unless related to Covered Services)
18. Surgery
19. Urology

(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
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
20. Private duty nursing only when approved in advance by Us
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
22. Allogenic bone marrow transplants
23. Autologous bone marrow transplants and associated high dose 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.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND 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.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician 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.

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.

3. 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.

(e) **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered 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] 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. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a Covered Service or Supply under the Group Health Care Plan 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 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 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.

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 and Radiation Therapy.

(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.

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 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.

V. 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, unless it is required as a result of an Illness or Injury sustained while covered under the Group Health Care Plan or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; 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.

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.

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 astigmation (blurring).

Services or supplies provided by one of the following members of Your **family:** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

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.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Evidence of Coverage.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit 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.

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 insulin needles and insulin syringes.

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: We do not cover services for Pre–Existing Conditions until Members have been covered by this Group Health Care Plan for six months. See the "Definitions" section of this Evidence of Coverage for the definition of a Pre–Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for A Member's Pre–Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Group Health Care Plan started, i.e., there is no intervening lapse in coverage.]

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 a **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.**

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). 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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 Evidence of Coverage.

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.

VI. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VII. COORDINATION OF BENEFITS AND SERVICES

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 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 [Carrier] is 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;
d. Supplemental Limited Benefits Insurance coverages; nor
e. 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 Group Health Care Plan or any other plan. 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 if 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 first or provides services, ignoring all other plans. The secondary plans then 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 divorced parents, the following governs which plan pays 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 person 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 the Group Health Care Plan when services 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 Group Health Care Plan;
b. PIP; or
c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Group Health Care Plan without application of Cash Deductibles and Co–Payments, if any or Co–Insurance.

"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 Group Health Care Plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Group Health Care Plan. 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 Group Health Care Plan may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selections regarding primacy of health coverage.

This Group Health Care Plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contract Holder's plan. In that case this Group Health Care Plan will be primary.

If there is a dispute as to which policy is primary, this Group Health Care Plan will pay benefits or provide services as if it were primary.

Services this Group Health Care Plan will provide if it is primary to PIP or OSAIC.

If this Group Health Care Plan 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 AND SERVICES** section of this Group Health Care Plan will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Group Health Care Plan will pay if it is secondary to PIP or OSAIC.

If this Group Health Care Plan 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 Co–Payments, or

b. the equivalent value of services if this Group Health Care Plan had been primary.

VIII. MEMBER 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.

CONFIDENTIALITY

Information contained in the medical record 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 Group Health Care Plan 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 by law.

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.

CONVERSION PRIVILEGE

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

GOVERNING LAW

This entire Group Health Care Plan is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Group Health Care Plan is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Group Health Care Plan, 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 Group Health Care Plan, the holder of the card must be a Member on whose behalf all applicable premium charges under this Group Health Care Plan have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Group Health Care Plan 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 Group Health Care Plan shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including, but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Group Health Care Plan, or similar causes, the rendition of medical or hospital benefits or other services provided under this Group Health Care Plan is delayed or rendered impractical. We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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 Contract Holder 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 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.

If the Contract replaces the contract of another insurer or carrier, We may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from the Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. 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.

2. Neither the Contract Holder 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 Group Health Care Plan.

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

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.

LIMITATION OF SERVICES

Except in cases of Medical Emergency, services 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.

MEDICAL NECESSITY

Members will receive designated benefits under the Group Health Care Plan only when Medically Necessary and Appropriate. We may determine whether any service or supply provided [or arranged] under the Group Health Care Plan was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity 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 Group Health Care Plan 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 Group Health Care Plan.

NOTICES AND OTHER INFORMATION

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

If to Us: To Our last address on record.

If to 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.

REFERRAL FORMS

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

Member will be responsible for the cost of all 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.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under the Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Group Health Care Plan subject to all applicable confidentiality requirements as defined in this Evidence of Coverage. By accepting coverage under this Group Health Care Plan, Subscriber, 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.

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 from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. 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.

[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.]

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.

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he or she attains the Group Health Care Plan's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when Your coverage ends.

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

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 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 and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage 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.]

IX. 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 Group Health Care Plan's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this 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 this 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 this Group Health Care Plan:

If a Member elects to continue his or her group health benefits under both this 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, and therefore;
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 this 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. Any person who becomes covered under the Group Health Care Plan during a continuation provided by this section is not a qualified continuee.

If 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 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, he or she 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.

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 You from Your 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 or her 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's 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; 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 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 disabled qualified continuee who has elected an additional 11 months of continuation, 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 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 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 Care 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 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 covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

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 evidence of good health 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:

- the Employer must allow for a leave of absence under Federal law and, therefore

- the section applies to You.

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, or
c. the date on which Your coverage would have ended had You not been on leave.

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. 180 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 YOUR MARRIAGE ENDS

If Your 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 Group Health Care Plan on the date the group health coverage ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been covered under this Group Health Care Plan for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be excessively covered; or
- [if he or she permanently relocates outside the Service Area.]

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.

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.

X. 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 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 pay any benefits under this Group Health Care Plan or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part 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.

XII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

(1) In the case of an Employee, the Employee is not retired.
(2) In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.
(3) The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE

For a Member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

(1) The Member, if eligible, has enrolled in Parts A and B of Medicare.
(2) The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

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).

EXHIBIT Z

PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD/MAIL)**
[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 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:
   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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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 or Mental and Nervous Conditions and Substance Abuse.

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 containing nicotine or other smoking deterrent medication.
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.]

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).

EXHIBIT Z

PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD)**
[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 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:
   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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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 or Mental and Nervous Conditions and Substance Abuse.

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 containing nicotine or other smoking deterrent medication.
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.]

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).

EXHIBIT Z

PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE **(MAIL)**
[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 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:
   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 and 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 under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered 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 or Mental and Nervous Conditions and Substance Abuse.

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 containing nicotine or other smoking deterrent medication.
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.]

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).

EXHIBIT Z

PART 4

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, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse 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 and 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 [$15.00] 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. 30 days of Inpatient care per Calendar Year; and
b. 20 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 [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.]

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).

EXHIBIT AA

PART 1

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD/MAIL)
Contract Holder:
Group Contract No.
Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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."

CO–PAYMENT

A Member 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 Group Health Plan provides 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, 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 or Mental or Nervous Condition.

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. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. 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.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. 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.

s. 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 Workers' 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).

EXHIBIT AA

PART 2

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD)
Contract Holder:
Group Contract No.
Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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."

CO–PAYMENT

A Member 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 Group Health Plan provides 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, 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 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. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs used in connection with baldness.
o. 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.
p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
q. Drugs dispensed to a Member while on active duty in any armed force.
r. 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.
s. 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 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).

EXHIBIT AA

PART 3

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (MAIL)
Contract Holder:
Group Contract No.
Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] 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 We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered 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 as 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 Participating Provider 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."

CO–PAYMENT

A Member 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 Group Health Plan provides any benefit for the Prescription Drug. The Co–Payment for each prescription or refill which is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Co–Payment 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; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

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. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs used in connection with baldness.
o. 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.
p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
q. Drugs dispensed to a Member while on active duty in any armed force.
r. 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.
s. 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 Workers' 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).

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 in triplicate to the SEH Board at the address specified at N.J.A.C. 11:21–1.3 and to the New Jersey Department of Insurance as follows: Attn: SEH Form Certification of Compliance, 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 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.

____ (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) All 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 at Exhibits H, and I and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

____ (e) All riders applicable to HMO 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.

____ (f) All applications, certifications, enrollment forms, waiver forms, certificates or evidences of coverage comply with the SEH Board's forms set forth in Exhibits N, O, Q, R, S, T, V, W, Y, Z, and AA, and the Explanation of Brackets set forth at Exhibit X 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

(1) List all plans to be offered as a traditional contract, if any.

_____
_____
_____
_____
_____

(2) List all plans to be offered in conjunction with a selective contracting arrangement (defined at N.J.A.C. 11:4–37), if any.

_____
_____
_____
_____
_____

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the coinsurance differentials and whether the plan requires election of a primary care physician.

_____
_____
_____
_____
_____

(4) Do 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) List the riders being offered, if any, and specify which plans with which they will be offered.

_____
_____
_____
_____
_____

(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?
(Note: 75% participation.)
____ Yes ____ No
If No, has the Board approved the carrier's use of an alternate participation requirements?
____ Yes ____ No

(8) Do the plans include any of the following as set forth by the SEH Board?

i. Utilization Review Features
____ 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

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

(b) HMO Plan

(1) List the copayment options being offered.

_____
_____
_____
_____
_____

(2) How is the in-plan prescription drug coverage being offered? _____

(3) List the riders being offered, if any, and specify the plan with which they will be offered.

_____
_____
_____

(4) Do the participation requirements comply with applicable statutes and rules?
(Note: 75% participation)
____ Yes ____ No
If No, has the Board approved the carrier's use of an alternate participation requirement?
____ Yes ____ No

(c) Additional Forms

(1) Is the Health Statement form, 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, in accordance with N.J.A.C. 11:21–7.4, no stop loss or excess risk insurance shall be issued or renewed for any small employer for which the company provides administrative services, and further, that all small employers or groups of small employers for which this company may act as administrator utilize self-funded plans meeting the definition of 26 U.S.C. 1002(1), the specifications of 26 U.S.C. 1002(4)(B) if a group of small employers, and are not multiple employer welfare arrangements, in whole or in part, as defined at 26 U.S.C. 1002(40).

Date _____ Signature _____

Title _____

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

EXHIBIT BB

PART 2

CERTIFICATION OF PROMOTIONAL AND MARKETING MATERIAL

Submit this form pursuant to N.J.A.C. 11:21–17.3 and annually thereafter 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 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 the small employer health benefits plans (Plans A, B, C, D, E and HMO), 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 _____

Title _____

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

EXHIBIT BB

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

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

EXHIBIT BB

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 _____

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

EXHIBIT CC
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM
CARRIER SMALL EMPLOYER MARKET SHARE REPORT

This report must be completed in accordance with the provisions of N.J.A.C. 11:21–10, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier. Reports must be completed and returned on or before April 15, 1994 and by March 1 of each year thereafter. Completed Reports must be returned to the SEH Program Administrator as set forth at N.J.A.C. 11:21–1.3.

Part A. Carrier Information
1. Carrier's Name: _____
2. Carrier's NAIC Number: _____
3. Is the above named Carrier an affiliated Carrier? _____ Yes _____ No
   a. If Yes, please list all Carriers with whom the above named Carrier is affiliated. List only those affiliates that had group health benefits plans in force for small employers in the preceding calendar year.

   Name NAIC #

   _____
   _____
   _____
   _____

Part B. Personal Respondent Information
1. Name: _____
2. Title: _____
3. Mailing Address: _____

_____
4. Telephone No. _____ Facsimile No. _____

Part C. Calendar Year Information for 199__
Net earned premium for all small employer group health benefits plans: $_____

Part D. Certification
I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:21–X.

Signature _____ Title _____ Date _____

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

Exhibit DD

[Carrier]

AMENDMENT

[Policyholder]

Group [Policy] No.

Effective Date:

[

]

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

[Carrier shall insert its standard amendment closure and signature blocks.]

EXHIBIT EE

(RESERVED)

EXHIBIT FF
SEH PROGRAM PREMIUM COMPARISON SURVEY

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

Part 1
COMPANY AND RESPONDENT INFORMATION

Company Name: _____ NAIC: _____

Respondent's Name: _____

Respondent's Title: _____

Respondent's Address: _____

Respondent's Telephone: _____

Respondent's Facsimile: _____

Part 2

TOLL–FREE INFORMATION

Company's Toll–Free Telephone number where an applicant may obtain a premium quote: _____

Please indicate if a switchboard or message recording is reached by the toll-free number and the respective period of service:

Switchboard Service Times: _____

Message Recording Service Times: _____

Part 3

DIRECTIONS FOR COMPLETING THE PREMIUM SURVEY

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

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

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

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

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

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

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

Part 4

PREMIUM SURVEY

PLAN A

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY___

PLAN A PREMIUM 1/1/19___

Camden

$250	NR $_____

Middlesex

$250	$_____

Bergen

$250	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional ____

SCA—No Gatekeeper ____

SCA—Gatekeeper ____

Other Delivery Systems Available: Yes ___ No ___

Note: Coinsurance percentages for Plan A are established by rule -- no variations are permitted. See Exhibit A of Appendix to N.J.A.C. 11:21.

PLAN B

Carrier: _____

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

Camden

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

Middlesex

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

Bergen

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

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper ____

Coinsurance Percentage:

In–Network ____ Copay (if any) $____

Out-of-Network ____

SCA—Gatekeeper ____

Coinsurance Percentage:

In–Network ____ Copay (if any) $____

Out-of-Network ____

Other Delivery Systems Available: Yes ____ No ____.

PLAN C

Carrier: _____

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

Camden

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

Middlesex

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

Bergen

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

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN D

Carrier: _____

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

Camden

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

Middlesex

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

Bergen

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

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN E

Carrier: _____

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

Camden

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

Middlesex

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

Bergen

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

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In–Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

HMO PLAN

Carrier: _____

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

Camden

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

Middlesex

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

Bergen

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

Premium Rate Guarantee Period (if any): _____

LIST OF MUNICIPALITIES REQUIRING PAYMENT OF LIENS BY COMPANIES WRITING FIRE INSURANCE

The following is a list of municipalities that have passed an ordinance requiring companies writing fire insurance on risks located in that municipality to pay unpaid liens out of any claimed payments in excess of $2,500. An asterisk (*) denotes an addition to the list since the previous date of publication.

	Date Filed with the Department of Insurance
Aberdeen, Township of 07747 (Monmouth County)	September 8, 1980
Absecon, City of 08201 (Atlantic County)	July 5, 1983
Alloway, Township of 08079 (Salem County)	December 20, 1984
Asbury Park, City of 07712 (Monmouth County)	May 25, 1979
Atlantic City, City of 08401 (Atlantic County)	March 19, 1979
Barrington, Borough of 08007 (Camden County)	September 17, 1982
Bayonne, City of 07002 (Hudson County)	March 12, 1979
Belmar, Borough of 07719 (Monmouth County)	March 5, 1982
Berkeley, Township of 08721 (Ocean County)	May 22, 1979
Berlin, Borough of 08009 (Camden County)	October 18, 1979
Berlin, Township of 08091 (Camden County)	March 20, 1980
Bloomfield, Town of 07003 (Essex County)	March 26, 1979
Bordentown, Township of 08505 (Mercer County) *	October 24, 1994
Branchburg, Township of 08876 (Somerset County)	December 15, 1992
Brick, Township of 08723 (Ocean County)	May 2, 1980
Bridgeton, City of 08302 (Cumberland County)	April 30, 1979
Brigantine, City of 08203 (Atlantic County)	October 14, 1982
Buena, Borough of 08341 (Atlantic County)	November 1, 1982
Burlington, City of 08016 (Burlington County)	December 9, 1986
Butler, Borough of 07405 (Morris County)	November 14, 1980
Byram, Township of 07860 (Sussex County)	October 9, 1980
Camden, City of 08101 (Camden County)	May 4, 1979
Cape May, City of 08204 (Cape May County)	May 22, 1979
Carneys Point, Township of 08069 (Salem County)	July 2, 1979
Cedar Grove, Township of 07009 (Essex County)	August 10, 1979
Chatham, Township of 07928 (Morris County)	June 4, 1986
Chesterfield, Township of 08620 (Burlington County)	September 16, 1994

	Date Filed with the Department of Insurance
Cinnaminson, Township of 08077 (Burlington County)	August 30, 1979
Clinton, Township of 08801 (Hunterdon County)	December 10, 1981
Delaware, Township of 08557 (Hunterdon County)	October 15, 1992
Delran, Township of 08075 (Burlington County)	August 30, 1979
Dover, Town of 07801 (Morris County)	April 16, 1980
Dover, Township of 08753 (Ocean County)	September 26, 1979
East Orange, City of 07019 (Essex County)	February 20, 1979
East Windsor, Township of 08520 (Mercer County)	December 23, 1991
Eatontown, Borough of 07724 (Monmouth County)	March 23, 1979
Edgewater Park, Township of 08010 (Burlington County)	July 24, 1979
Egg Harbor, Township of 08221 (Atlantic County)	September 24, 1979
Egg Harbor, City of 08215 (Atlantic County)	May 21, 1981
Elizabeth, City of 07201 (Union County)	April 30, 1979
Elmer, Borough of 08318 (Salem County)	November 19, 1991
Ewing, Township of 08618 (Mercer County)	November 10, 1981
Fairfield, Township of 07006 (Essex County)	August 21, 1980
Fair View, Borough of 07022 (Bergen County)	September 5, 1979
Fanwood, Borough of 07023 (Union County)	June 29, 1979
Farmingdale, Borough of 07727 (Union County)	May 18, 1981
Florham Park, Borough of 07932 (Morris County)	April 25, 1979
Fort Lee, Borough of 07024 (Bergen County)	August 27, 1979
Franklin, Township of 07826 (Somerset County)	June 20, 1980
Fredon, Township of 07860 (Sussex County)	October 28, 1980
Freehold, Borough of 07728 (Monmouth County)	July 21, 1994
Freehold, Township of 07728 (Monmouth County)	October 8, 1992
Gloucester, City of 08030 (Camden County)	January 24, 1989
Green, Township of 07821 (Sussex County)	July 20, 1982
Hackensack, City of 07602 (Bergen County)	April 22, 1980
Haddon Heights, Borough of 08035 (Camden County)	August 8, 1994
Hamilton, Township of 08330 (Atlantic County)	November 18, 1982
Hamilton, Township of 08650 (Mercer County)	August 2, 1994
Hammonton, Town of 08037 (Atlantic County)	August 3, 1979
Hanover, Township of 07981 (Morris County)	January 7, 1986
Hightstown, Borough of 08520 (Mercer County)	September 3, 1980
Hillside, Township of 07205 (Union County)	June 4, 1979
Hoboken, City of 07030 (Hudson County)	October 15, 1979
Holland, Township of 08848 (Hunterdon County)	June 1, 1992
Holmdel, Township of 07733 (Monmouth County)	October 20, 1987
Hopewell, Township of 08302 (Cumberland County)	September 26, 1979
Hopewell, Township of 08560 (Mercer County) *	October 14, 1994
Howell, Township of 07731 (Monmouth County)	March 23, 1979
Irvington, Town of 07111 (Essex County)	March 20, 1979
Irvington, Township of 07111 (Essex County)	July 1, 1985
Jackson, Township of 08257 (Ocean County)	March 7, 1979
Jamesburg, Borough of 08831 (Middlesex County)	March 2, 1983
Jefferson, Township of 07981 (Morris County)	April 19, 1983
Jersey City, City of 07302 (Hudson County)	February 23, 1979
Keansburg, Township of 07734 (Monmouth County)	April 5, 1984
Kearny, Town of 07032 (Hudson County)	August 26, 1980
Keyport, Borough of 07735 (Monmouth County)	August 15, 1979
Kinnelon, Borough of 07405 (Morris County)	June 4, 1986
Lacey, Township of 08731 (Ocean County)	August 18, 1981
Lavallette, Borough of 08735 (Ocean County)	December 11, 1979
Lawrence, Township of 08648 (Mercer County)	April 24, 1979
Lindenwold, Borough of 08021 (Camden County)	July 6, 1994
Little Silver, Borough of 07739 (Monmouth County)	April 5, 1984
Logan, Township of 08096 (Gloucester County)	January 2, 1990
Long Branch, City of 07740 (Monmouth County)	December 4, 1987
Lopatcong, Township of 08865 (Warren County)	August 30, 1979
Lower, Township of 08024 (Cape May County)	June 5, 1979
Manchester, Township of 08733 (Ocean County)	September 21, 1982
Mannington, Township of 08079 (Salem County)	May 17, 1979
Maple Shade, Township of 08052 (Burlington County)	July 18, 1980
Maplewood, Township of 07040 (Essex County)	April 4, 1979
Matawan, Borough of 07747 (Monmouth County)	June 19, 1981
Maurice River, Township of 08332 (Cumberland County)	September 26, 1980
Medford Lakes, Borough of 08055 (Burlington County)	February 3, 1992
Mendham, Township of 07949 (Morris County)	January 16, 1985
Millburn, Township of 07041 (Essex County)	May 19, 1981
Millville, City of 08332 (Cumberland County)	April 10, 1979
Millstone, Township of 07726 (Monmouth County)	January 14, 1988
Montclair, Town of 07042 (Essex County)	April 5, 1979
Mount Holly, Township of 08060 (Burlington County)	January 29, 1980
Mount Laurel, Township of 08054 (Burlington County)	May 27, 1980
Neptune, Township of 07753 (Monmouth County)	January 4, 1982
Neptune City, Borough of 07712 (Monmouth County)	December 2, 1982
Newark, City of 07102 (Essex County)	March 16, 1979
New Brunswick, City of 08903 (Middlesex County)	January 30, 1986
North Plainfield, Borough of 07060 (Somerset County)	July 1, 1985
North Wildwood, City of 08260 (Cape May County)	August 24, 1979
Ocean, Township of 07755 (Monmouth County)	November 27, 1979
Ocean, Township of 08758 (Ocean County)	May 29, 1985
Orange, City of 07050 (Essex County)	July 2, 1979
Passaic, City of 07055 (Passaic County)	September 4, 1980
Paterson, City of 07050 (Passaic County)	February 16, 1979
Paulsboro, Borough of 08066 (Gloucester County)	May 7, 1981
Pemberton, Township of 08057 (Burlington County)	August 9, 1993
Penns Grove, Borough of 08069 (Salem County)	July 9, 1979
Phillipsburg, Town of 08865 (Warren County)	July 13, 1979
Pine Hill, Borough of 08021 (Camden County)	March 2, 1982
Piscataway, Township of 08854 (Middlesex County)	March 20, 1981
Pittsgrove, Township of 08318 (Salem County)	January 8, 1993
Plainfield, City of 07061 (Union County)	April 5, 1979
Pleasantville, City of 08232 (Atlantic County)	December 27, 1979
Plumsted, Township of 08533 (Ocean County)	November 16, 1992
Pohatcong, Township of 08865 (Warren County)	July 20, 1979
Princeton, Borough of 08540 (Mercer County)	July 16, 1980
Princeton, Township of 08540 (Mercer County)	September 25, 1980
Rahway, City of 07065 (Union County)	December 18, 1979
Randolph, Township of 07801 (Morris County)	May 10, 1979
Readington, Township of 08889 (Hunterdon County)	June 23, 1980
Red Bank, Borough of 07701 (Monmouth County)	September 9, 1980
Riverside, Township of 08075 (Burlington County)	May 10, 1979
Roosevelt, Borough of 08555 (Monmouth County)	March 3, 1992
Roselle, Borough of 07203 (Union County)	August 8, 1979
Roselle Park, Borough of 07204 (Union County)	March 5, 1981
Runnemede, Borough of 08078 (Camden County)	May 6, 1982
Salem, City of 08079 (Salem County)	June 20, 1979
Sayreville, Borough of 08872 (Middlesex County)	September 19, 1979
Scotch Plains, Township of 07076 (Union County)	August 22, 1979
Sea Bright, Borough of 07760 (Monmouth County)	April 10, 1979
Sea Girt, Borough of 07762 (Monmouth County)	March 12, 1991
Seaside Heights, Borough of 08751 (Ocean County)	June 21, 1991
Secaucus, Town of 07094 (Hudson County)	March 5, 1980
Somerdale, Borough of 08083 (Camden County)	July 28, 1982
Somers Point, City of 08244 (Atlantic County)	June 3, 1993
Somerville, Borough of 08876 (Somerset County)	March 23, 1979
South Amboy, City of 08879 (Middlesex County)	July 12, 1984
South Harrison, Township of 08039 (Gloucester County)	December 29, 1988
South Orange Village, Township of 07079 (Essex County)	August 19, 1980

	Date Filed with the Department of Insurance
South Plainfield, Borough of 07080 (Middlesex County)	September 26, 1980
South River, Borough of 08882 (Middlesex County)	March 16, 1979
Spotswood, Borough of 08884 (Middlesex County)	June 19, 1981
Stafford, Township of 08050 (Ocean County)	May 2, 1985
Sussex, Borough of 07461 (Sussex County)	October 24, 1979
Tenafly, Borough of 07670 (Bergen County)	June 17, 1980
Tewsbury, Township of 08833 (Hunterdon County)	August 21, 1992
Tinton Falls, Township of 07724 (Monmouth County)	June 20, 1980
Trenton, City of 08608 (Mercer County)	June 12, 1980
Tuckerton, Borough of 08087 (Ocean County)	February 2, 1989
Union City, City of 07087 (Hudson County)	April 23, 1979
Upper Deerfield, Township of 08302 (Cumberland County)	May 19, 1989
Upper Pittsgrove, Township of 08318 (Salem County)	October 15, 1979
Ventnor City, City of 08401 (Atlantic County)	March 30, 1982
Verona, Borough of, Township of 07044 (Essex County)	February 23, 1984
Victory Gardens, Borough of 07801 (Morris County)	August 15, 1979
Vineland, City of 08360 (Cumberland County)	July 6, 1979
Washington, Borough of 07882 (Warren County)	June 24, 1986
Washington, Township of 08214 (Burlington County)	March 12, 1979
Washington, Township of 07853 (Morris County)	May 30, 1979
Waterford, Township of 08004 (Camden County)	July 9, 1984
Wayne, Township of 07470 (Passaic County)	October 6, 1986
Weehawken, Township of 07087 (Hudson County)	August 14, 1986
Wenonah, Borough of 08090 (Gloucester County)	July 1, 1985
West Deptford, Township of 08086 (Gloucester County)	November 14, 1988
Westfield, Town of 07090 (Union County)	July 15, 1992
Westhampton, Township of 08060 (Burlington County)	June 4, 1979
West New York, Town of 07093 (Hudson County)	March 16, 1979
Westville, Borough of 08093 (Gloucester County)	March 18, 1988
West Orange, Town of 07052 (Essex County)	February 26, 1979
Westwood, Borough of 07675 (Bergen County)	November 28, 1991
Wildwood, City of 08260 (Cape May County)	December 5, 1984
Willingboro, Township of 08046 (Burlington County)	April 17, 1980
Winslow, Township of 08037 (Camden County)	November 13, 1980
Woodbury, City of 08086 (Gloucester County)	January 7, 1986
Woodlynne, Borough of 08107 (Camden County)	June 7, 1982
Woodridge, Borough of 07075 (Bergen County)	July 9, 1984
Woodstown, Borough of 08079 (Salem County)	September 8, 1983
Woolwich, Township of 08085 (Gloucester County)	March 28, 1994

R.1980 d.115, filed May 1, 1980.
See: 12 N.J.R. 196(a).
As amended, R.1980 d.190, filed May 1, 1980.
See: 12 N.J.R. 342(a).
As amended, R.1980 d.219, filed May 15, 1980.
See: 12 N.J.R. 342(b).
As amended, R.1980 d.268, filed June 19, 1980.
See: 12 N.J.R. 422(b).
As amended, R.1980 d.336, filed July 29, 1980.
See: 12 N.J.R. 538(c).
As amended, R.1981 d.221, filed June 8, 1981.
See: 13 N.J.R. 441(b).
As amended, R.1982 d.33, filed January 21, 1982.
See: 14 N.J.R. 213(b).
As amended, R.1982 d.133, filed April 7, 1982.
See: 14 N.J.R. 432(c).
As amended, R.1984 d.273, filed June 6, 1984.
See: 16 N.J.R. 1803(a).
Amended, R.1985 d.82, filed January 25, 1985.
See: 17 N.J.R. 616(b).
Public Notice: Added 141 through 149 to General Information.
See: 18 N.J.R. 1109(b).
Public Notice: Added 150 through 156 to General Information.
See: 19 N.J.R. 146(e).
Public Notice: Published General Information list.
See: 19 N.J.R. 1658(d).
Public Notice: Published General Information list.
See: 20 N.J.R. 2402(a).
Public Notice: Added City of Gloucester, South Harrison Twp. and Tuckerton Boro.
See: 21 N.J.R. 936(c).
Public Notice: List of municipalities requiring payment of liens by companies writing fire insurance; added East Windsor, Elmer, Holland Township, Logan Township, Medford Lakes, Roosevelt, Sea Girt, Seaside Heights, Upper Deerfield Township, West Deptford Township, Westfield and Westwood.
See: 24 N.J.R. 3181(b).
Public Notice: Publication of revised list, January 3, 1994.
See: 26 N.J.R. 262(b).
Public Notice: Publication of revised list, July 18, 1994.
See: 26 N.J.R. 3087(b).
Public Notice: Publication of revised list, November 7, 1994.
See: 26 N.J.R. 4453(a).
Public Notice: Publication of revised list, April 3, 1995.
See: 27 N.J.R. 1485(b).
Public Notice: Publication of revised list, July 3, 1995.
See: 27 N.J.R. 2631(a).

LIST OF UNAUTHORIZED INSURERS WHICH QUALIFY AS ELIGIBLE SURPLUS LINES INSURERS

Historical Note

The "List of Unauthorized Insurers Which Qualify as Eligible Surplus Lines Insurers" was originally filed as R.1984 d.296 and appeared at this location. See: 16 N.J.R. 2001. A new list, which replaced the original filing, was adopted as a part of R.1994 d.7 and codified as Appendix A of N.J.A.C. 11:1–34, effective January 3, 1994. See: 26 N.J.R. 236(b).