Late Enrollee means an eligible Employee [or Dependent] who requests enrollment under this Policy more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** [and **Dependent Coverage]** section[s] of this Policy.

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 Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Planholder" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

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

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

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.

Pre-Existing Condition means for a Covered Person who is age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests and Nicotine Dependence Treatment.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

Public Health Plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

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

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct a Covered Person to a Facility or Practitioner for health care.]

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in this Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Substance Abuse means abuse of or addiction to drugs or alcohol.

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.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any therapy services that are received under the Home Health Care provision.

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, bone density testing, screening tests and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person[, $300 per Covered Family].

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $100 and $300 limits do not apply to services from a Network Practitioner.

Immunizations and Lead Screening
[Carrier] will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

[Transplant Benefits
[Carrier] covers charges for:

a) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
b) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has Specialty Case Management. 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 **Specialty Case Management** 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, Specialty Case Management or Centers of Excellence Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:
a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

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
Carriers must include the disclosure requirements set forth in N.J.A.C. 11:24A-3.2.

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-Emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. [For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.]

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission;
d) the name and location of the Hospital;
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out-come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%],** if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

[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.]

Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%] if:**
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

[SPECIALTY CASE MANAGEMENT
Important Notice: No Covered Person is required, in any way, to accept a Specialty Case Management Plan recommended by [DEF].

Definitions
"Specialty Case Management" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by [Carrier] 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) While there are other covered services and supplies available under this Policy for the Covered Person's condition, the services and supplies the [Carrier] offers to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: [Carrier] has sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) substance abuse
l) mental illness
m) any other Illness or Injury determined by [DEF] or (Carrier] to be catastrophic.

Specialty Case Management 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 a Specialty Case Management Plan.

A Specialty Case Management 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 Specialty Case Management 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 a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon Specialty Case Management treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion
Specialty Case Management 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.

The amount of any charge which is greater than an ***Allowed Charge.***

Services for ***ambulance*** for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances and dental implants.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***dose-intensive chemotherapy***[, except as otherwise stated in this Policy.]

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility.***

Services or supplies related ***to hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***herbal medicine.***

Services or supplies related to ***hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

Except as stated below, 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. ***Exception***: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental Illness 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.***

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

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

Services provided by a ***pastoral counselor*** *in* the course of his or her normal duties as a religious person.

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 in the Home Health Care section of this Policy.

Prosthetic Devices

Services or supplies related to ***rest or convalescent cures***.

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker***, except as otherwise stated in this Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital except as stated below, or unless the services are for treatment:
- of a non-service Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and under military health coverage and who receive care in facilities of the Uniformed Services.

e) provided outside the United States unless the Covered person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or
- Subject to [Carrier] Pre-Approval, eligibility for full-time student status, provided the Covered person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age;
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) A Covered Person who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30-month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30-month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary plan. This Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).

Late Enrollee means an eligible Employee [or Dependent] who requests enrollment under this Policy more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** [and **Dependent Coverage**] section[s] of this Policy.

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 Illness. [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 Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

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

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

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

["DC" Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [Network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of a [Non-Network] provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.

Pre-Existing Condition means ,for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

Public Health Plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

[Referral means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct a Covered Person to a Facility or Practitioner for health care.]

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, 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.

Specialized Infant Formulas
[Carrier] covers specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Policy] for Prescription Drugs. [Carrier] covers specialized non-standard infant formulas provided:
a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
[Carrier] may review continued Medical Necessity and Appropriateness of the specialized infant formula.

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
[Subject to [Carrier] Pre-Approval, for certain Prescription Drugs] [Carrier] covers drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* 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 Hospital Formulary Service Drug Information;
    2. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.
Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.
And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[[Carrier] has identified certain Prescription Drugs for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. [Carrier] will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact [Carrier] to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact [Carrier] to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. [Carrier] will review the Pre-Approval request within the time period allowed by law. If [Carrier] gives Pre-Approval, [Carrier] will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Policy. If [Carrier] does not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is a PPO or a POS)

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact [Carrier] to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after [Carrier] makes a decision regarding Pre-Approval or may choose to purchase the Prescription Drug prior to the decision being made. In either case, the Covered Person must pay for the Prescription Drug when it is dispensed. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. If [Carrier] does not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

Supplies to Administer Prescription Drugs
[Carrier] covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
[Carrier] covers practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. [Carrier] will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

[Carrier] does not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Policy for treatments that are not Experimental or Investigational.]

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 was not caused, directly or indirectly by biting or chewing; and
b) 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.

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

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.

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, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.
Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
[Carrier] covers charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger [Covered Persons] who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Covered Person's] Practitioner in consultation with the [Covered Person] regarding methods to use, [Carrier] will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

[Carrier] will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Covered Person's] practitioner in consultation with the [Covered Person.]

High risk for colorectal cancer means a [Covered Person] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a [Covered Person] may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier]

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a Covered Person who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].; 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;
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease; or
c) A Covered Person who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary Plan. This Policy is the secondary Plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R.596(a).

EXHIBIT G

[Carrier] HMO PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)CONTRACT

CONTRACTHOLDER:	[ABC Company]
GROUP CONTRACT NUMBER [G-12345]	**GOVERNING JURISDICTION** NEW JERSEY
EFFECTIVE DATE OF CONTRACT:	[September 23, 2010]
CONTRACT ANNIVERSARIES:	[September 23rd of each year, beginning in 2011]
PREMIUM DUE DATES:	[Effective Date, and the 23rd day of the month beginning with October 2010.]
AFFILIATED COMPANIES:	[DEF Company]

[Carrier], in consideration of the application for this Contract and the payment of premiums as stated herein, agrees to arrange [or provide] services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

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

[Secretary President]

["DC" THIS SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS HMO PLAN AND THE INDEMNITY PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Members]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:
Covered Employee Only ..... $]

[Covered Employee and Spouse..... $

Covered Employee and Child(ren)..... $

Covered Employee and Family ..... $
(including Covered Employee, spouse and one or more eligible dependents)]

We have the right to prospectively change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled "General Provisions."

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee [and covered Dependents, if any)].

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. 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 ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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] PROVIDER. A Provider which is not a [Network] Provider.
NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

OUTPATIENT. [Member], if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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

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

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

["DC" POINT OF SERVICE PLAN. Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] Providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [Network] Provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [Non-Network] Provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Specific direction or instruction from a Network Practitioner or from Us in conformance with Our policies and procedures that authorizes a [Member] to use a Provider for health care services or supplies.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition. See the **Non-Covered Services and Supplies** section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.]

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

a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
   - The American Hospital Formulary Service Drug Information;
   - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.
In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PRIMARY CARE PHYSICIAN (PCP). A [Network] 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.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

PUBLIC HEALTH PLAN. Any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that direct a [Member] to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, 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 or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

7. **Procedures and Prescription Drugs to enhance fertility,** except where specifically excluded in this Contract. We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8. **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network.

Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.

9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Physician and arranged through Us.
10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider.
    [A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the [Member's] Network Provider.
    A supply will be considered to be furnished at the time the Prescription Drug is received.]

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Member must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of this Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in this Contract.]

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

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

15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19) Newborn Hearing Screening We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

20) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior written Referral by a [Member]'s Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS**. The following services are covered when hospitalized by a Network Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:
1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Network Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
a) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

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

2. Private accommodations [will be provided only when Pre-Approved 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 Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility 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

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare. Benefits will be payable as specified in the COORDINATION OF BENEFITS AND SERVICES section of this Contract.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **COORDINATION OF BENEFITS AND SERVICES** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.
A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner]..

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, this Contract is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if a ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).

[**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Planholder" definition is employed, references in the 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 the Policy to "Policyholder" should be changed to read "Planholder"]

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

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased 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.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.

Pre-Existing Condition means for a Covered Person who is age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests and Nicotine Dependence Treatment.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

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

Public Health Plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct a Covered Person to a Facility or Practitioner for health care.]

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in the Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least eligible two Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:
a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Substance Abuse means abuse of or addiction to drugs or alcohol.

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.

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.

Urgent Care means care for a non-life threatening condition that requires care by a Provider within 24 hours.

[**Waiting Period** means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.]

[**We, Us, Our** and **[Carrier]** mean [Carrier].]

[**You, Your and Yours** means an Employee who is insured under the Policy.]

"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.

[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies for Hospice Care which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.

Pregnancy
The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges
[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

Anesthetics
[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible 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 the Policy's EMPLOYEE COVERAGE and [DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is under age 19 and who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. [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.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any therapy services that are received under the Home Health Care provision.

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, bone density testing, screening tests and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person[, $300 per Covered Family].

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $100 and $300 limits do not apply to services from a Network Practitioner.

Immunizations and Lead Screening
[Carrier] will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Dental care or treatment, including appliances and dental implants.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***dose-intensive chemotherapy***[, except as otherwise stated in the Policy.]

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility.***

Services or supplies related ***to hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***herbal medicine.***

Services or supplies related to ***hypnotism.***

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

Except as stated below, 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. ***Exception***: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental Illness 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.***

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of the Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in the Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.

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

Services provided by a ***pastoral counselor*** *in* the course of his or her normal duties as a religious person.

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 in the Home Health Care section of the Policy.

Prosthetic Devices

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 and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital except as stated below, or unless the services are for treatment:
- of a non-service Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both the Policy and under military health coverage and who receive care in facilities of the Uniformed Services.

e) provided outside the United States unless the Covered person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or
- Subject to [Carrier] Pre-Approval, eligibility for full-time student status, provided the Covered person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by [Carrier] are Non-Covered Charges.**

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants [, except as otherwise stated in the Policy.].

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products and except as provided in the Food Products for Inherited Metabolic Diseases provision.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

STATEMENT OF ERISA RIGHTS
The following Statement 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 these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

[CLAIMS PROCEDURE
Carriers should include claims procedures consistent with the requirements of ERISA.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Repeal and New Rule, R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).

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 Illness. [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 Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges or which exceed any of the benefit limits shown in the Policy, 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.

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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 the 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 the Policy to "Policyholder" should be changed to read "Planholder"]

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

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

["DC" Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [Network] provider (subject to any necessary authorization from his or her Primary Care Physician) or those of a [Non-Network] provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased 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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.

Pre-Existing Condition means for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

Public Health Plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct a Covered Person to a Facility or Practitioner for health care.]

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, 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 the Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the

1. The American Hospital Formulary Service Drug Information;
2. The United States Pharmacopeia Drug Information; or

c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[[Carrier] has identified certain Prescription Drugs for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. [Carrier] will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact [Carrier] to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact [Carrier] to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. [Carrier] will review the Pre-Approval request within the time period allowed by law. If [Carrier] gives Pre-Approval, [Carrier] will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the Policy. If [Carrier] does not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of the Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in the Policy.] (Note to Carriers: For use if the plan is a PPO or a POS)

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact [Carrier] to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after [Carrier] makes a decision regarding Pre-Approval or may choose to purchase the Prescription Drug prior to the decision being made. In either case, the Covered Person must pay for the Prescription Drug when it is dispensed. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of the Policy. If [Carrier] does not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in the Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

Supplies to Administer Prescription Drugs
[Carrier] covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
[Carrier] covers practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. [Carrier] will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

[Carrier] does not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under the Policy for treatments that are not Experimental or Investigational.]

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 was not caused, directly or indirectly by biting or chewing; and
b) 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.

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

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.

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, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
[Carrier] covers charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger [Covered Persons] who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Covered Person's] Practitioner in consultation with the [Covered Person] regarding methods to use, [Carrier] will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

[Carrier] will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Covered Person's] practitioner in consultation with the [Covered Person.]

High risk for colorectal cancer means a [Covered Person] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible 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 the Policy's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [[Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits,][Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Policyholder has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

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The following Statement 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 these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

[CLAIMS PROCEDURE
Carriers should include claims procedures consistent with the requirements of ERISA.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Administrative correction.
See: 44 N.J.R. 2184(a).

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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 the Contract.

NON- [NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

OUTPATIENT. [Member], if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such Outpatient settings.

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

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

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

["DC" POINT OF SERVICE PLAN. Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] Providers under an Indemnity Plan. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a [Network] Provider (subject to any necessary authorization from his or her Primary Care Physician) or those of an [Non-Network] Provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision. Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Specific direction or instruction from a Network Practitioner or from Us in conformance with Our policies and procedures that authorizes a [Member] to use a Provider for health care services or supplies.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition. See the **Non-Covered Services and Supplies** section of the Contract for details on how the Contract limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;

b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PRIMARY CARE PHYSICIAN (PCP). A [Network] 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.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

PUBLIC HEALTH PLAN. Any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that direct a [Member] to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

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

b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, 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 or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

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

b) be approved for its stated purpose by Medicare.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females)].

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

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.

10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider.
[A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Network Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Member must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of the Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in the Contract.]

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

    For the purpose of this benefit:
    "inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
    "low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
    "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.
15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
    a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
    b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
    We may review continued Medical Necessity and Appropriateness of the specialized infant formula.
16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

    We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

    We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.
18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

    Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:
    a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
    b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
    c) Stool DNA (sDNA) test with high sensitivity for cancer
    d) flexible sigmoidoscopy,
    e) colonoscopy;
    f) contrast barium enema;
    g) Computed Tomography (CT) Colonography
    h) any combination of the services listed in items a – g above; or
    i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19) **Newborn Hearing Screening** We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

20) **Hearing Aids** We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior written Referral by a [Member]'s Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:

1. Semi-private room and board accommodations
   Except as stated below, We provide coverage for Inpatient care for:
   a) a minimum of 72 hours following a modified radical mastectomy; and
   b) a minimum of 48 hours following a simple mastectomy.
   Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Network Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

   As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
   a) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and
   b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.
   We provide such coverage subject to the following:
   a) the attending Practitioner must determine that Inpatient care is medically necessary; or
   b) the mother must request the Inpatient care.
   [As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when Pre-Approved 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 Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestines.
22. Allogeneic bone marrow transplants.

Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).

EXHIBIT Z

(RESERVED)

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit Z: Rider for Prescription Drug Insurance".

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$0] Copayment/visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment/visit	Deductible/Coinsurance
Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using separate deductible/coinsurance and maximum out of pocket for network and non-network services)

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Primary Care Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Emergency Room	[$50] Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Prescription Drugs	Non-Network Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per Calendar Year

Network
Per Covered Person [$250 to $2,500]
[Per Covered Family [Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Non-Network
Per Covered Person [Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family [Dollar amount equal to two times the Non-Network Deductible] **Note**: Must be individually satisfied by 2 separate Covered Persons

Coinsurance
Network [50% - 10%, in 5% increments]
Non-Network [50% - 10%, in 5% increments]

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Contract is as follows:
Per member per Calendar Year [An amount not to exceed $7,500]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]
Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The Non-**Network Maximum Out of Pocket** for this Policy is as follows:
Per Member per Calendar Year [An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Member Maximum.] [**Note:** Must be individually satisfied by 2 separate Member]]
Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using common deductible and maximum out of pocket for network and non-network services but separate coinsurance)

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Primary Care Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Emergency Room	[$50] Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance
Prescription Drugs	Non-Network Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per Calendar Year

Network and Non-Network

Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Coinsurance

Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.

The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

LIMITATIONS ON SERVICES AND SUPLIES

Unless otherwise stated, the following limitations represent the maximum number of days or visits for use of any combination of Network and Non-Network Providers.

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined)	
Network:	Unlimited
Non-Network:	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical or occupational therapy per Calendar Year (combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows:	
Network:	Unlimited
Non-Network: (Not subject to Cash Deductible or Coinsurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$750 per Member]
• for all [other] Members	$500 per Member
Charges for hearing aids for Members age 15 or younger	Maximum benefit $1,000 per hearing impaired ear per 24-month period
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	
Network:	Unlimited
Non-Network:	Unlimited

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THIS CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

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

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

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

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

ACCREDITED SCHOOL. A school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

ALLOWED CHARGE. With respect to [Network] services and supplies, the negotiated arrangement.

With respect to [Non-Network] benefits, Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by Us, based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is an Allowed Charge under this Contract. For charges that are not determined by a negotiated fee schedule, the [Covered Person] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

[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 or INJURED. Damage to a [Member's] body, and all complications arising from that damage, or a description of a [Member] suffering from such damage.

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

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

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under this Contract more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage [and Dependent Coverage] subsection[s] of the **Eligibility** section of this Contract.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. 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 ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-COVERED CHARGES. Charges which do not meet this Contract's definition of Covered Charges or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by this Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in this Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

OUTPATIENT. [Member], if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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

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

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Our approval using paper or electronic means for specified services and supplies prior to the date the charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise by payable under the Contract.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of this Contract for details on how this Contract limits the services and benefits for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.
In no event will We pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[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, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies [other than Prescription Drugs] for the remainder of the Calendar Year.]

[Once two Members in a family meet their individual Maximum Out of Pocket, no other Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred during the Calendar Year in which this Contract starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Contract would have provided coverage for the charges if this Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

Note to carriers: The Coverage Provision section is only to be included in plans where Network coverage is subject to deductible and coinsurance.]

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine gynecological exams and related services;
d) Routine ear and hearing examination; and
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 and Appropriate by a [Member's] Primary Care Physician and Pre-Approved by Us.
7) **Procedures and Prescription Drugs to enhance fertility**, except where specifically excluded in this Contract. We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8) **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network.

Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.

9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.
10) [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.
[A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] [Network] Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]
[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Member must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us

to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of this Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in this Contract.]

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and Pre-Approved by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14) **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

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

15) **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16) Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17) **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18) **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:

a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19) **Newborn Hearing Screening** We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.
20) **Hearing Aids** We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically

necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.
NOTE: ANY HEARING AID BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] HEARING AID SERVICES AND SUPPLIES.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS**. Except as stated below, the following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network] Facilities subject to Our Pre-Approval); however, [Network] Skilled Nursing Facility Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval.
Exception: If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

1. Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the [Network] Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.
- As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
⇒ a minimum of 48 hours of Inpatient care in a [Network] Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of Inpatient care in a [Network] Hospital following a cesarean section.
- We provide such coverage subject to the following:
⇒ the attending Practitioner must determine that Inpatient care is medically necessary; or
⇒ the mother must request the Inpatient care.
- [As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.
19. The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
20. Allogeneic bone marrow transplants.
[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]
[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
21. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]
24. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR MENTAL ILLNESS OR SUBSTANCE ABUSE.** We cover treatment of a Mental Illness or Substance Abuse the same way We would for any other Illness, if such treatment is prescribed by a [Network] Provider upon prior written Referral by a [Member]'s Primary Care Physician [or the Care Manager]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Physician in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
II. We will cover the cost of services and supplies in connection with an Emergency provided within or outside our service area without a prior Referral only if:
A. Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
B. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
C. We and a [Member's] Primary Care Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
III. In the event a [Member] is hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior Referral or the [Member] shall be responsible for payment.
5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a [Member] is admitted as an Inpatient to the Hospital as a result of the Emergency.
6) Coverage for Emergency and Urgent Care include coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provides coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Emergency medical condition exists. [Please note that the "911" Emergency response system may be used whenever a Covered person has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

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.
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* - except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a [Covered Person] who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a [Covered Person] who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a [Covered Person's] ability to perform the ordinary tasks of daily living.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Contract.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

We will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Contract.

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

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

Specialized Infant Formulas
We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
c) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
d) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[Subject to Our pre-Approval for certain Prescription Drugs,]We cover drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.
[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.

[If a [Member] brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the [Member] must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Contract. If We do not give Pre-Approval, the [Member] may ask that the Pharmacy dispense the balance of the Prescription Drug, with the [Member] paying for the Prescription Drug. The [Member] may submit a claim for the Prescription Drug, subject to the terms of this Contract. The [Member] may appeal the decision by following the Appeals Procedure process set forth in this Contract.]

Supplies to Administer Prescription Drugs
We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the [Member] during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a [Member] receives medical care associated with an Approved Cancer

Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a [Member] to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Contract for treatments that are not Experimental or Investigational.]

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

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

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of this Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every year, for a female [Member] ages 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female [Member] may elect to apply any unused Preventive Care allowance for a mammogram. If a [Member] has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member.]

High risk for colorectal cancer means a [Member] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a [Member] may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Member has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.
A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE AS SECONDARY PAYOR (Continued)

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, this Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

New Rule, R.1996 d.200, effective April 15, 1996.
See: 28 N.J.R. 27(a), 28 N.J.R. 2042(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]	
Copayment	
For Preventive Care	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	[$50], credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

[NON-NETWORK]	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	$2,500]
Per Covered Family	[$5,000 NOTE: Must be individually satisfied by 2 separate [Members]] [$7,500]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	
for Preventive Care	NONE
for all other Covered Charges	[30%, 20%]
Network Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS

[NETWORK]	Unlimited, **except** as otherwise stated
[NON-NETWORK]	$Unlimited

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Hospital		
Inpatient (unlimited days)	[$150] Copayment/day; maximum/admission [$750]; maximum/cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment/visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	[$50] Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$0] Copayment/visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment/visit	Deductible/Coinsurance
Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using separate deductible/coinsurance and maximum out of pocket for network and non-network services)

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Primary Care Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Emergency Room	[$50] Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	Coinsurance	Coinsurance
Preventive Care	No Copayment Deductible or Coinsurance	No Deductible or Coinsurance
Prescription Drugs	Non-Network Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per Calendar Year

Network	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]
Non-Network	
Per Covered Person	[Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible] **Note**: Must be individually satisfied by 2 separate Covered Persons

Coinsurance
Network [50% - 10%, in 5% increments]
Non-Network [50% - 10%, in 5% increments]

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Contract is as follows:
Per member per Calendar Year [An amount not to exceed $7,500]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]
Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
The Non-**Network Maximum Out of Pocket** for this Policy is as follows:
Per Member per Calendar Year [An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Member Maximum.] [**Note:** Must be individually satisfied by 2 separate Member]]
Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using common deductible and maximum out of pocket for network and non-network services but separate coinsurance)

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Primary Care Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Emergency Room	[$50] Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance
Prescription Drugs	Non-Network Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per Calendar Year

Network and Non-Network
Per Covered Person [$250 to $2,500]
[Per Covered Family [Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Coinsurance
Network [50% - 10%, in 5% increments]
Non-Network [50% - 10%, in 5% increments]

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.

The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

LIMITATIONS ON SERVICES AND SUPPLIES

Unless otherwise stated, the following limitations represent the maximum number of days or visits for use of any combination of Network and Non-Network Providers.

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined)	
Network:	Unlimited
Non-Network:	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical or occupational therapy per Calendar Year (combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows:	
Network:	Unlimited
Non-Network: (Not subject to Cash Deductible or Coinsurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$750 per Member]
• for all [other] Members	$500 per Member
Charges for hearing aids for Members age 15 or younger	Maximum benefit $1,000 per hearing impaired ear per 24-month period
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	
Network:	Unlimited
Non-Network:	Unlimited

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Our approval using paper or electronic means for specified services and supplies prior to the date the charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise by payable under the Contract.

PRE-EXISTING CONDITION. For a member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of the Contract for details on how the Contract limits the services and benefits for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.
In no event will We pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

PUBLIC HEALTH PLAN. Any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the Care Manager] in conformance with Our policies and procedures that direct a [Member] to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.
In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

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

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges**.

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of a registered nurse or licensed practical nurse.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least eligible two Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

SPECIAL CARE UNIT. A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:
a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.
a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Code Terminology as Surgery.

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

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in the Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

determination of fraud, or where Our medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the Contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the [Member] to continue treatment with the terminated health care professional.

In case of pregnancy of a [Member], coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the [Member], up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a [Member] who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a [Member] who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a [Member] receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under Contract or agreement with Us.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under Contract with Us.

If a [Member] is admitted to a health care Facility on the date the Contract is terminated, We shall continue to provide benefits for the [Member] until the date the [Member] is discharged from the Facility or exhaustion of the [Member's] benefits under the Contract, whichever occurs first.

We shall not continue services in those instance in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of Contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a [Member's] continued treatment with a health care professional shall be subject to the appeal procedures set forth in the Contract. We shall not be liable for any inappropriate treatment provided to a [Member] by a health care professional who is no longer employed by or under Contract with Us.

If We Refer a [Member] to a [Non-Network] provider, the service or supply shall be covered as a [Network] service or supply. We are fully responsible for payment to the health care professional and the [Member's] liability shall be limited to any applicable [Network] Copayment, or Coinsurance for the service or supply.]

COVERED SERVICES AND SUPPLIES ***APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES***

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [Cash Deductible] [or Coinsurance] as stated in the applicable Schedule and subject to the terms, conditions and limitations of the Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

[COVERAGE PROVISION

The Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[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, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies [other than Prescription Drugs] for the remainder of the Calendar Year.]

[Once two Members in a family meet their individual Maximum Out of Pocket, no other Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:

a) the charges were incurred during the Calendar Year in which this Contract starts or during the 90 days preceding the effective date whichever is the greater period;
b) this Contract would have provided coverage for the charges if this Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

Note to carriers: The Coverage Provision section is only to be included in plans where Network coverage is subject to deductible and coinsurance.]

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine gynecological exams and related services;
d) Routine ear and hearing examination; and
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 and Appropriate by a [Member's] Primary Care Physician and Pre-Approved by Us.
7) **Procedures and Prescription Drugs to enhance fertility**, except where specifically excluded in the Contract. We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8) **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance. The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network. Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.
9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.
10) [Subject to Our Pre-Approval, as applicable, **]Prescription Drugs** [including **contraceptives]** ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.

[A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] [Network] Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Member must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of the Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in the Contract.]

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.
11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

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

15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and

b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.

17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:

a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19) Newborn Hearing Screening We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

20) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

NOTE: ANY HEARING AID BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] HEARING AID SERVICES AND SUPPLIES.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** Except as stated below, the following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network] Facilities subject to Our Pre-Approval); however, [Network] Skilled Nursing Facility Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval.

Exception: If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the [Network] Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

- As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:

⇒ a minimum of 48 hours of Inpatient care in a [Network] Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of Inpatient care in a [Network] Hospital following a cesarean section.

- We provide such coverage subject to the following:

⇒ the attending Practitioner must determine that Inpatient care is medically necessary; or
⇒ the mother must request the Inpatient care.

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

2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities!
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions

Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

19. The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
20. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

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

21. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]
24. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR MENTAL ILLNESS OR SUBSTANCE ABUSE.** We cover treatment of a Mental Illness or Substance Abuse the same way We would for any other Illness, if such treatment is prescribed by a [Network] Provider upon prior written Referral by a [Member]'s Primary Care Physician [or the Care Manager]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:

a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Physician in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
II. We will cover the cost of services and supplies in connection with an Emergency provided within or outside our service area without a prior Referral only if:

A. Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
B. The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
C. We and a [Member's] Primary Care Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for

Blood
Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the [Member].

Charges for the Treatment of Hemophilia
[Carrier] covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

[[Carrier] will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for the [Carrier's] network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by [Carrier's] network clinical laboratory.

[Carrier] will pay the Hospital's clinical laboratory for the laboratory services at the same rate [Carrier] would pay a Network clinical laboratory for comparable services.]

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) replacements or repairs; or
b) 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.

We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under the Contract.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Contract.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of the Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

We will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by Us provided that benefits would otherwise be payable under the Contract.

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

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

Specialized Infant Formulas
We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

c) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
d) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[Subject to Our pre-Approval for certain prescription Drugs,]We cover drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.
[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.

[If a [Member] brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the [Member] must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the Contract. If We do not give Pre-Approval, the [Member] may ask that the Pharmacy dispense the balance of the Prescription Drug, with the [Member] paying for the Prescription Drug. The [Member] may submit a claim for the Prescription Drug, subject to the terms of the Contract. The [Member] may appeal the decision by following the Appeals Procedure process set forth in the Contract.]

Supplies to Administer Prescription Drugs
We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the [Member] during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a [Member] receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a [Member] to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under the Contract for treatments that are not Experimental or Investigational.]

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

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

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of the Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every year, for a female [Member] ages 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female [Member] may elect to apply any unused Preventive Care allowance for a mammogram. If a [Member] has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

New Rule, R.1996 d.199, effective April 15, 1996.
See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).