

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

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

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

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

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

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

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

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

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

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

ii. The standard health benefit plans as either indemnity plans or in conjunction with a selective contracting arrangement, or both in all geographic areas within its approved service area.

3. If an insurer with a limited approved service area chooses to offer the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and

later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(g) A carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute shall offer the standard health benefits plans whether as indemnity plans or as PPO or POS plans in all geographic areas of the State.

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

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

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

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

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

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

1. \$75.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only), \$5.00 copayment for all other copayments, and prescription drugs at either a \$5.00 copayment or at the non-network coinsurance level;

2. \$100.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only), \$10.00 copay-

ment for all other copayment, and prescription drugs at either a \$10.00 copayment or at the non-network coinsurance level;

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

4. \$250.00 hospital inpatient copayment excluding mental/nervous and substance abuse, \$200.00 non-biologically based mental illness hospital inpatient copayment \$50.00, separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only), \$20.00 copayment for all other copayments, and prescription drugs at either a \$20.00 copayment or at the non-network coinsurance level;

5. \$300.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only), prescription drugs at either a \$30.00 copayment or at the non-network coinsurance level and a \$30.00 copayment for all other copayments.

Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).

See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

In (a), (d), and (e), substituted "standard health benefits plan" for "small employer health benefits plan"; added (a)8; in (d), deleted reference to HMO Plan; in (d)3, deleted reference to out-network benefits; and added (f) through (h).

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (a), changed Exhibit references throughout, and added "as well as text which is unique to Plans B, C, D and E, where such Plan unique text is clearly identified" at the end of 6; in (b), substituted a reference to Exhibits A, F, V and W for a reference to Exhibits A through F in the introductory paragraph; and in (d), rewrote the introductory paragraph and 1, and substituted a reference to Exhibits F and G for a reference to Exhibits B through G in 2.

Amended by R.2000 d.304, effective June 23, 2000.

See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).

In (b), inserted a new 3, and reclassified former 3 as 4; inserted (c)4; and in (h), substituted "non-biologically based mental illness" for "mental/nervous and substance abuse" following "\$200.00" in 4, and added 5.

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

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

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

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

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

- i. Exhibit H, part 1 (mail order and card);
- ii. Exhibit H, part 2 (card only); or
- iii. Exhibit H, part 3 (mail order only).

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

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

- i. Exhibit J, part 1 (mail order and card);
- ii. Exhibit J, part 2 (card only); or
- iii. Exhibit J, part 3 (mail order only).

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

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

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

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

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

ii. Deductibles, Coinsurance, Copayments, Coinsured Charge Limits, and Coinsurance Caps of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first

dollar coverage), and their applicability in situations involving common accident; and

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

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

i. Provider networks;

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

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

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

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

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

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

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

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

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

vi. For riders of increasing value only, submit copies of a certification signed by a duly authorized officer of the member that states clearly:

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

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

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

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

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

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

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

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

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

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

(f) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit riders.

Amended by R.1994 d.418, effective July 15, 1994.

See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).

Amended by R.1995 d.116, effective March 6, 1995.

See: 26 N.J.R. 4729(a), 27 N.J.R. 918(a).

Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).

See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Inserted "standard" preceding "optional benefits riders" and inserted reference to HMO POS throughout; in (a), inserted "standard" preceding "health benefits plan"; in (d)3i, added text "and the 'Covered Services and Supplies,' ... HMO POS plan"; in (d)3iii, inserted reference to Eligibility and Continuation Rights sections of the HMO POS plan; in (d)4ii and (d)5, deleted reference to vision coverage and benefits; in (d)7i, amended submission requirements and added (d)7vi(5).

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (d), deleted a reference N.J.A.C. 11:21-12 in 1, deleted a former 5, recodified former 6 through 8 as 5 through 7 and made a corresponding internal reference change, added "For riders of increasing value only," at the beginning of vi and deleted "plan not approved by the Commissioner" at the end of vi(1) in the new 6; and added (f).

SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

11:21-3A.1 Purpose and scope

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

11:21-3A.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT H

CARD/MAIL
SEH-OR-1A

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an illness or injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an inpatient in a facility. But [Carrier] only covers drugs which are:

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

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

In no event will [Carrier] pay for:

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

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

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and

d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
- c) needed to treat an illness or injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
- b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
- c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles

- syringes
- support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-1B

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

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

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

In no event will [Carrier] pay for:

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

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

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center

- an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
- or similar institution.
- h) Charges for:
- therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-1C

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

- a) Legend Drugs

- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Mail Order Pharmacy for take-home use; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
 - and other non-medical substances, regardless of their intended use.

- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

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

[Carrier should insert Standard Rider Closure.]

Amended by R.1994 d.47, effective December 22, 1993.
 See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
 Amended by R.1994 d.498, effective September 2, 1994.
 See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
 Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
 See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
 Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
 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).

EXHIBIT I

SEH-OR-2

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:
Group Policy No:
Effective Date:

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and Substance Abuse and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only- covers drugs which are:

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

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

In no event will [Carrier] pay for:

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

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

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate: