For all other Covered Charges

[per Covered Person	[the greater of: $XXXX or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$XXXX] [$XXXX or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$XXXX]]
[per Covered Family	[the greater of: $XXXX or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$XXXX] [$XXXX or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$XXXX]]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	[30%, 20%]

Maximum Out of Pocket

Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person or Covered Family, as applicable, must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person or Covered Family, as applicable, has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

[per Covered Person	[the greater of $XXXX or the maximum amount permitted under Internal Revenue Code 223]]
[per Covered Family	[the greater of $XXXX or the maximum amount permitted under Internal Revenue Code 223]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE

EXAMPLE PPO
(using Plan C, without Copayment, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[dollar amount not to exceed $2,500]
Per Covered Family	[2 times per Covered Person dollar amount]

For treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE

New Jersey State Library

for all other Covered Charges

Per Covered Person	[Dollar amount equal to 2 times the network deductible]
Per Covered Family	[Dollar amount equal to 2 times the non-network deductible]

Emergency Room Copayment
(waived if admitted within 24 hours) $[100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered person maximum]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person 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 Covered Person per Calendar Year	[An amount not to exceed 2 times the Network maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the Covered Person maximum]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE **EXAMPLE PPO**
(using Plan C, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Copayment
For treatment, services and supplies given by a **Network** Provider

For Preventive Care	NONE
For Physician Visits for all other Covered Charges	[dollar amount not to exceed $50]

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs

Per Covered Person	[dollar amount not to exceed $2,500]
Per Covered Family	[2 times per Covered Person dollar amount]]

For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the Network Deductible]
Per Covered Family	[Dollar amount equal to 2 times the Non-Network Deductible]

Emergency Room Copayment

(waived if admitted within 24 hours)	$[100]

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	30%

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket

Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person 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 Covered Person per Calendar Year	[An amount not to exceed 2 times the network maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE

EXAMPLE PPO
(using Plan C, with Copayment on specified services, common Deductible and Maximum Out of Pocket)

Copayment
For treatment, services and supplies given by a **Network** Provider
For Preventive Care NONE
For Physician Visits for all other Covered Charges [dollar amount not to exceed $50]
Maternity Care (pre-natal visits) NONE

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network or Non-Network** Providers, except for services listed in the Copayment section
Per Covered Person [dollar amount not to exceed $2,500]
Per Covered Family [2 times per Covered Person dollar amount]

Emergency Room Copayment
(waived if admitted within 24 hours) $[100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to any combination of Network and Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:
For Preventive Care: 0%
For Prescription Drugs [30%]
[Vision Benefits (for Covered Persons through the age of 18)
V2500 – V2599 Contact Lenses [50%]
Optional lenses and treatments [50%]]

[Dental Benefits (for Covered Persons through the age of 18)
Preventive, Diagnostic and Restorative services 0%
Endodontic, Periodontal, Prosthodontic and
Oral and Maxillofacial Surgical Services [20%]
Orthodontic Treatment [50%]]
For all other services and supplies:
• if treatment, services or supplies are given by a
Network Provider 10%
• if treatment, services or supplies are given by a
Non-Network Provider 30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. All amounts 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year [An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year [Dollar amount equal to 2 times the per Covered person maximum]
Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person 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 Covered Person per Calendar Year [An amount not to exceed 2 times the network maximum]
Per Covered Family per Calendar Year [Dollar amount equal to 2 times the per Covered Person maximum]
Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE

EXAMPLE POS
(using Plan D, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Copayment
For treatment, services and supplies given by a **Network** Provider

For Preventive Care	NONE
For Physician Visits for all other Covered Charges	[dollar amount not to exceed $50]
Maternity Care (pre-natal visits)	NONE
Hospital Confinement	[an amount equal to 10 times the above copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]

Exception: If the Hospital is a Network facility, the Hospital will be paid as a Network Facility regardless of whether the admitting Practitioner is a Network Practitioner.

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for services listed under the Copayment section and Prescription Drugs

Per Covered Person	[dollar amount not to exceed $2,500]
[Per Covered Family	[2 times per Covered Person amount]

For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the Network Deductible]
[Per Covered Family	[Dollar amount equal to 2 times the Non-Network Deductible]

Emergency Room Copayment
(waived if admitted within 24 hours) $[100]
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	20%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum.]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket

Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person 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 the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person Maximum.]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE

EXAMPLE PPO
(using Plan C, without Copayment, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[dollar amount not to exceed $2,500]
Per Covered Family	[2 times per Covered Person dollar amount]

For treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the network deductible]
Per Covered Family	[Dollar amount equal to 2 times the non-network deductible]

Emergency Room Copayment

(waived if admitted within 24 hours) [$100]

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%

Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person 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 Covered Person per Calendar Year	[An amount not to exceed 2 times the Network Maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person Maximum.]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE **EXAMPLE EPO (with PCP Copayment)**

IMPORTANT: Except in case of Emergency all services and supplies must be provided by a Network Provider.

Copayment
Primary Care Physician Visits [dollar amount not to exceed $50]

[Specialist Visits	an amount not to exceed $75]

Maternity Care(pre-natal visits)NONE
[All [other] Practitioner Visits an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]

[Hospital Confinement	[an amount equal to 10 times the above PCP copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]]

Calendar Year Cash Deductible

For treatment, services and supplies	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
[for Prescription Drugs	NONE, $250]
for visits subject to copayment	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount not to exceed $2,500]
Per Covered Family	[2 times per Covered Person dollar amount]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
[Note, this Policy limits the amount a Covered Person is required to pay for each 30-day supply of a prescription. See the Prescription Drug Coinsurance Limit.]

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

For Preventive Care:	0%
For Primary Care Physician Visits	0%
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For treatment, services or supplies given by any other Network Provider	[20%, 30%, 40%, 50%][**, except as stated below]**
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below.]

[For Prescription Drugs	
Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,600 or amount permitted by 45 C.F.R. 156.130]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

[Prescription Drug Coinsurance Limit:	[$125] per 30 day supply]

[Prescription Drug Coinsurance Limit:	
Preferred Drugs	[$125] per 30 day supply
Non-Preferred Drugs	[$250] per 30 day supply]

SCHEDULE OF INSURANCE **EXAMPLE EPO (with Copayments for most services)**

IMPORTANT: Except in case of Emergency all services and supplies must be provided by a Network Provider.

Calendar Year Cash Deductible

For treatment, services and supplies	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
[for Prescription Drugs	NONE, [$250]]
for all other Covered Charges	
Per Covered Person	[an amount not to exceed the Maximum Out of Pocket]
Per Covered Family	[an amount equal to 2 times the per covered person amount]

b) While there are other covered services and supplies available under this Policy for the Covered Person's condition, the services and supplies We offer to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: We have 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) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or Us 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) [Us].

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 We, [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 maximums.

Exclusion
Specialty Case Management does not include services and supplies that We determine 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 Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of 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 the ***Allowed Charge.***

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

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

[Broken appointments.]

Services or supplies for which the Provider has not obtained a ***certificate of need*** or such other approvals as required by law.

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, except as otherwise stated in this Policy.

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

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

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

Extraction of teeth, except as otherwise stated in this Policy.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy for Covered Persons through age 18, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) except as otherwise stated in this Policy for Covered Persons through age 18 eyeglasses or lenses of any type; this exclusion does not apply to 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 Your ***family:*** Spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

Except as stated in the Newborn Hearing Screening and Hearing Aids provisions, 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.

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP OR CIVIL UNION ENDS
If Your marriage ends by legal divorce or annulment, or Your domestic partnership or civil union dissolves, the individual coverage for Your former Spouse ends. The former Spouse may convert to an individual contract during the conversion period. The former Spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Policy on the date this coverage ends. See **Exceptions** below.

Exceptions
No former Spouse may use this conversion right:
if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered. This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage.
HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date this 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 coverage under this Policy ends.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her Spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When You file proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will determine to pay either the Covered Person or the Facility or the Practitioner.] You may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS
We, at our expense, have the right to examine the insured. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Repeal and New Rule, R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2010 d.247, effective October 4, 2010.
See: 42 N.J.R. 2366(a), 42 N.J.R. 2632(b).
Amended by R.2012 d.167, effective September 13, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2237(a), 44 N.J.R. 2365(a).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).

SKILLED NURSING FACILITY/ EXTENDED CARE CENTER — Unlimited days, if Pre-Approved; [amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment per day.

THERAPY SERVICES — [amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.
[COMPLEX IMAGING SERVICES — [amount consistent with N.J.A.C. 11:22-5.5(a)]]

[ALL OTHER] DIAGNOSTIC SERVICES
INPATIENT — $0 Copayment
(OUTPATIENT) — [$amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit

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 and Supplies in a Calendar Year. All amounts 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 and Supplies for the remainder of the Calendar Year.

The **Maximum Out of Pocket** for this Contract is as follows:
- Per Member per Calendar Year — [$6,600 or amount permitted by 45 C.F.R. 156.130]
- Per Family per Calendar Year [$2X per member amount.]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Services and Supplies.

SCHEDULE OF SERVICES AND SUPPLIES — [Example Using Deductible, Coinsurance]

The services or supplies covered under this Contract are subject to the Copayments, Deductible and Coinsurance set forth below and are determined per Calendar Year per [Member], unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT
For Primary Care Physician but not for Preventive Care Visits — [amount consistent with N.J.A.C. 11:22-5.5(a)]] per visit
For Preventive Care — NONE
Maternity (pre-natal care) — NONE
For Prescription Drugs — Copayments consistent with N.J.A.C. 11:22-5.5]
For all other services and supplies — Copayment Not Applicable; Refer to the Deductible and Coinsurance sections

DEDUCTIBLE PER CALENDAR YEAR
- For Preventive Care and immunizations and lead screening for children — NONE
- Maternity (pre-natal care) — NONE.
- Second Surgical Opinion
- for all other Covered Services and Supplies
  - Per Member — [amount not to exceed $2500]
  - Per Covered Family — amount equal to 2 times the per member amount.]

COINSURANCE
[For Prescription Drugs — 50%]
For Preventive Care: — NONE
For all services and supplies to which a Copayment does not apply — [10% - 50%, in 10% increments]
For all services and supplies to which a Copayment applies — None

EMERGENCY ROOM COPAYMENT — $100 Copayment/visit/Member (waived if admitted within 24 hours).
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

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 and Supplies in a Calendar Year. All amounts 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 and Supplies for the remainder of the Calendar Year.

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

•Per Member per Calendar Year	[$6,600 or amount permitted by 45 C.F.R. 156.130]
•Per Family per Calendar Year	[$2X per member amount.]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Services and Supplies.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Speech Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Cognitive Rehabilitation Therapy	30 visits per Calendar Year
Physical Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Occupational Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision Note: These services are habilitative services in that they are provided to help develop rather than restore a function. (limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits
Charges for hearing aids for a Member age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval

[NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.]

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

SCHEDULE OF SERVICES AND SUPPLIES
Example HMO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges.)

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

<u>Adjunctive General Services</u>

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for <u>additional</u> time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
    - Hospital or ambulatory surgical center call
        - For cases that are treated in a facility.
        - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
        - General anesthesia and outpatient facility charges for dental services are covered
        - Dental services rendered in these settings by a dentist not on staff are considered separately
    - Office visit for observation – (during regular hours) no other service performed
f) Drugs
    - Therapeutic parenteral drug
        - Single administration
        - Two or more administrations - not to be combined with single administration
    - Other drugs and/or medicaments – by report
g) Application of desensitizing medicament – per visit

h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
  - Limited - (per visit)
  - Complete (regardless of the number of visits), once in a lifetime
k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as described in the Explanation of Brackets If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a child under age 6]
For a Member who is severely disabled or who is a child under age 6, We cover:
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 Contract which requires Hospitalization or general anesthesia.

(l) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Physician]. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to treatment of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(m) **THERAPEUTIC MANIPULATION** Therapeutic manipulation is covered when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Physician]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

(m) **[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.]

Clinical Trial. The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.

We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

(n) **Surgical Treatment of Morbid Obesity** Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.
For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE <u>NOT</u> COVERED SERVICES UNDER THIS CONTRACT.

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 the **Allowed Charge.**]

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

STATEMENTS
No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a [Member], and We furnish a copy to the[Member].

All statements will be deemed representations and not warranties.

TERM OF THE CONTRACT - RENEWAL PRIVILEGE – TERMINATION

All Contract Years and Contract Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

The Contractholder may renew this Contract for a term of one (1) year, on the first and each subsequent Renewal Date. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Contract on the Renewal Date following written notice to the Contractholder for the following reasons:
a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
b) subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage;
c) subject to 90 days advance written noticethe Board terminates a standard plan or a standard plan option;[or]
d) [with respect to coverage issued through the marketplace, decertification of the plan.]

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to marketplace requirements, if any.

<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any premium is not paid by the end of its grace period, the Contract will end as described in the Grace Period provision.

<u>Termination by Request</u> - If You want to replace this Contract with another individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as described In the Grace Period provision.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)
c) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
e) [You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]
f) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Member is no longer eligible for an exemption, or until the end of the plan year in which the Member attains age 30, whichever occurs first.

TERMINATION OF DEPENDENT COVERAGE
If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer a Dependent, as defined in the Contract. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

Also, Dependent coverage ends when the Contractholder's coverage ends.

THE CONTRACT
This Contract, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance.

WORKERS' COMPENSATION
The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP OR CIVIL UNION ENDS
If Your marriage ends by legal divorce or annulment, or Your domestic partnership or civil union dissolves, the individual coverage for Your former Spouse ends. The former Spouse may convert to an individual contract during the conversion period. The former Spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date this coverage ends. See **Exceptions** below.

Exceptions
No former Spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage. or
c) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date this 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 coverage under this Contract ends.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit F and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit B, repealed.
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2010 d.247, effective October 4, 2010.
See: 42 N.J.R. 2366(a), 42 N.J.R. 2632(b).
Amended by R.2012 d.167, effective September 13, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2237(a), 44 N.J.R. 2365(a).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).