11:21–10.5 Certification

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

11:21–10.6 Failure to comply

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

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

Authority

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

New Jersey State Library

Source and Effective Date

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

11:21–11.1 Purpose and scope

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

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

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

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

11:21–11.2 Definitions

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

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

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

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

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

11:21–11.3 Restricted withdrawal and marketing

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

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

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

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

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

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

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

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

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

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

1. A cover letter stating:

i. The name of the carrier, and the name, title, telephone number and telefax number of a contact

person familiar with the filing to whom the Department may direct any additional questions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

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

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

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

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

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

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

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

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

3. The most recent financial examination report;

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

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

6. The non-refundable filing fee.

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

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

(b) Carriers may elect to withdraw by nonrenewing policies, contracts or certificates at the time of the 12–month anniversary date of each such policy, contract or certificate, provided that:

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

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

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

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

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

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

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

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

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

2. The notice specifies the reason for the cancellation;

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

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

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

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

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

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

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

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

11:21–11.7 Other policyholder rights unaffected

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

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

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

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

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

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

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

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

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

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

11:21–11.9 Penalty and fines

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

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

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

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

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

SUBCHAPTERS 12 THROUGH 13. (RESERVED)

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

Authority

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

Source and Effective Date

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

11:21–14.1 Purpose and scope

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

11:21–14.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

11:21–14.3 General requirement

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

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

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

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

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

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

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

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

SUBCHAPTER 17. FAIR MARKETING STANDARDS

Authority

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

Source and Effective Date

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

11:21–17.1 Plan identification and marketing materials

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

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

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "standard" preceding "health benefits plan" throughout and inserted reference to HMO POS.

11:21–17.2 Retention of marketing and promotional materials

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

11:21–17.3 Certification

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

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis, on or before March 1 of each year following the filing of its initial certification.

Amended by R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "carrier" preceding "disseminates promotional or marketing"; and in (b), inserted March 1 deadline.

11:21–17.4 Buyers' Guide

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

11:21–17.5 Producer contracts

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

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

SUBCHAPTER 18. PETITIONS FOR RULES

Authority

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

Source and Effective Date

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

11:21–18.1 Scope

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

11:21–18.2 Procedure for petitioner

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

1. Name and address of the petitioner;

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

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

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

(b) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

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

11:21–18.3 Procedure of the Board

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

1. The name of the petitioner;

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

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

4. The date the petition was received.

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

1. The name of the petitioner;

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

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

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

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

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

1. Denying the petition;

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

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

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

Authority

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

Source and Effective Date

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

11:21–19.1 Purpose and scope

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

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

11:21–19.2 Definitions

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

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

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

11:21–19.3 SEH Program premium comparison survey

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

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

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

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

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

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

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

11:21–19.4 Penalties

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

APPENDIX

EXHIBIT A

PLAN A

[Carrier]

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER

[G–12345]

GOVERNING JURISDICTION

NEW JERSEY

EFFECTIVE DATE OF POLICY

[January 1, 1996]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1997.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1996]

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

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

[Secretary President]
[Dividends are apportioned each year.]

POLICY INDEX

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SCHEDULE OF INSURANCE AND PREMIUM RATES **PLAN A**

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

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

Medicare Alternate Deductible

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

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

Hospital Confinement Co-Payment

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

Co-Insurance

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

The **Co-Insurance** for this Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

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

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

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

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

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

• Extended Care and Rehabilitation

• Home Health Care

• Hospice Care

• Fertility Services

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

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

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

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

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by: a Network Provider	an Out-Network Provider
The **Co-Insurance** for this Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

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

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

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

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

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

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis* for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis* for Hospital days
Charges for Hospice Care	exchange basis* for Hospital days

* See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
—per Covered Family	$300
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

PREMIUM RATES

[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	**Premium Rate**
Health Benefits	
—per Employee	$9999.99]
[—per Employee and spouse	$9999.99
—per Employee and children	$9999.99
—per Employee, spouse and children	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;

b.] the Policyholder's application, a copy of which is attached to this Policy;

[c.] any riders, [endorsements] or amendments to this Policy and

[d.] the individual applications, if any, of the persons covered.

STATEMENTS

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or

b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

AMENDMENT

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the Conformity With Law section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

AFFILIATED COMPANIES

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees [and Dependents] then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee [and/or Depen-

dent] whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's [and/or Dependent's] coverage has ended.
b. The amount of any claims paid to an Employee for the Employee's claims [or to a member of the Employee's family unit] after that person's coverage has ended.]

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
   - by amendment or this Policy; or
   - by reason of any provision of law or any government program or regulation; or
   - if this Policy supplements or coordinates with benefits provided by another insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

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

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

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

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

CLERICAL ERROR-MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will not invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

TERMINATION OF THE POLICY-RENEWAL PRIVILEGE

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period-Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.

b. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;

c. with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

d. with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

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

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:01 a.m. eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer in accordance with the laws in the State of New Jersey.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the action described above as of the Employer's Policy Anniversary.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,

(2) any protection and rights when the coverage ends and

(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

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

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS-INFORMATION TO BE FURNISHED

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee [and Dependents] eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee [or Dependent] coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage should have ended.]

CLAIMS PROVISIONS

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

[NOTICE OF LOSS

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

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

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

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this Policy for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

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

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read this entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an Eligible Employee [or a Dependent] who is insured under this Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means an Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.]

[A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

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

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee [or Dependent,] as the context in which the term is used suggests.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

[**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

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

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

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs;
f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

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

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

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or **Pre-Approved** means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or

• the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

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

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

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

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

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center).

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

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

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

Substance Abuse means abuse of or addiction to drugs.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means:

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

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

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

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

[You, Your and Yours mean the Employer.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of this Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

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

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of an Employee's coverage.

When Employee Coverage Ends

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Policy.

c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are the Employee's:

a. legal spouse;
b. unmarried Dependent children who are under age 19; and
c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children,
b. his or her step-children if such step-children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and this Policy, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Policy's age limit;
b. the child became insured by this Policy or any other policy before the child reached the age limit, and stayed continuously insured after reaching such limit; and
c. the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent Coverage at the same time. Subject to the exception stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the Dependent's Eligibility Date, or
b. the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the Dependent's Eligibility Date for the Newly Acquired Dependent.

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

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under this Policy will end on the first of the following dates:

a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card].

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

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

c. ***Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her

to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services

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

Emergency Services

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

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

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

Utilization Review

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is issued as POS.]

[GRIEVANCE PROCEDURE: Carrier may elect to include a grievance procedure when the plans are issued including Preferred Provider Organization or Point of Service provisions. If a Carrier has had a Selective Contracting Arrangement approved by the New Jersey Departments of Insurance and Health it may include that approved Grievance Procedure language in the standard SEH forms.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or limited if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

[Family Deductible Limit

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.]

[Per Covered Family

The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the Per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Co-Insurance Cap

This Policy limits Co-Insurance amounts each Calendar Year except as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles; and
c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.]

[Coinsured Charge Limit

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

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. this Policy starts right after the old plan ends.

Extended Health Benefits

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Charges while Hospitalized

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board
b. Routine Nursing Care
c. Prescription Drugs

d. Blood transfusions
e. Infusion Therapy
f. Chemotherapy
g. Radiation Therapy
h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

As an exception to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b. a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or
b. the mother must request the in-patient care.

[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co-Payment per Calendar Year.

Testing Charges

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and

i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.

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

e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;

b. are not business associates of the Practitioner who recommended the Surgery; and

c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;

b. ordered by the Covered Person's Practitioner;

c. included in the Hospice care program; and

d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;

b. funeral services and arrangements;

c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy

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

Birthing Center Charges

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

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

[Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

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

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

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

Pre-Existing Conditions

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

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

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

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

[This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And] [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based, self-funded or other health benefit arrangement, prior to enrollment under this Policy. When this happens, if the previous plan provided coverage for a condition, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing, whether or not the previous plan paid benefits for the condition to the Covered Person. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

b. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the therapy Services listed below but **only** when provided on an Inpatient basis.

c. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

d. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

e. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Fertility Services

Subject to [Carrier] Pre-Approval [Carrier] covers charges for inpatient procedures to enhance fertility. Charges in connection with Fertility Services which are not Pre-Approved by [Carrier] or which are specifically excluded, are Non-Covered Charges.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, $300 per Covered Family.

[Transplant Benefits

[Carrier] covers charges for:

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

IMPORTANT NOTICE

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

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

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has

entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

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

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

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

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required

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

Pre-Hospital Review

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

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

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

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

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

Continued Stay Review

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

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

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

In case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

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

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

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

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

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

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

Pre-Hospital Review

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

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%**] if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: *No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].*

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous or psychoneurotic disorders

m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner;
   - Covered Person;
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: *No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.*

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

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

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

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

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

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

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

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an Illness or Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

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

Dental care or treatment, including appliances.

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

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

Durable Medical Equipment

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

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

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

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

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

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygotr Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

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

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

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

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

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

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

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

Care and treatment for ***Mental and Nervous Conditions and Substance Abuse.***

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

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

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

Non-prescription drugs or supplies, except

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

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

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care.

Practitioner visits, except as otherwise stated in this Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

Prosthetic Devices.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

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

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

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

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

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

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

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;
e. provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
   - [Subject to Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Stand-by services required by a Provider.

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

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

Telephone consultations.

Therapeutic Manipulation.

Transplants **[except as otherwise stated in this Policy].**

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date this Policy ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Covered Person becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person.

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing condition of the Covered Person, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying;
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence under Federal law in which case;
- the section applies to the Employee.

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-Time work;
b. the end of a total leave period of 12 weeks in any 12 month period;
c. the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d. the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or
b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

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

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

Request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

Request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made because an HMO becomes insolvent

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made at any other time

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

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

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law; or
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred

provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right to Certain Information

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFIT FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian; caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any overage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

Medicare

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

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

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

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

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

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the Coordination of Benefits section for a definition of "allowable expense."

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

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

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

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

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

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary

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

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of disability.

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

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare

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

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

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

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

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

When a Covered Person Becomes Eligible for Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary plan. This Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers, fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

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

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contract the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
   - the specific reason(s) the claim is denied;
   - specific references to the pertinent plan provision on which the denial is based;
   - a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
   - and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
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).

EXHIBIT B

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

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

Co-Insurance Caps	
Per Covered Person per each Calendar Year	$3,000
Per Covered Family per each Calendar Year	$6,000 [**Note:** Must be individually satisfied by 2 separate Covered Persons]

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

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

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

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

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

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

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Fertility Services
- Nutritional Counseling
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person

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

DEFINITIONS **[PLAN B]**

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

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

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

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

HEALTH BENEFITS INSURANCE **[PLAN B]**

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an exception to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and

b. a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or
b. the mother must request the in-patient care.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

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

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

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

Hospital Co-Payment Requirement

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

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, in addition to the Cash Deductible, any other Co-Payments, and Co-Insurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
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).

EXHIBIT C

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

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or 2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

The Co-Insurance for this Policy is as follows:	30%
Co-Insurance Caps	
Per Covered Person per each Calendar Year	$2,500
[Per Covered Family per each Calendar Year	$5,000 [**Note:** Must be individually satisfied

by 2 separate Covered Persons]]

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

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

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

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

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

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

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [• Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

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

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an exception to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b. a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or
b. the mother must request the in-patient care.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

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

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

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

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, in addition to the Cash Deductible, any other Co-Payments, and Co-Insurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an

Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
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).

EXHIBIT D

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

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

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,000
[Per Covered Family per each Calendar Year	$4,000 [Note: Must be individually satisfied by 2 separate Covered Persons]]

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

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

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

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

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

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

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [• Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer.]
- Fertility Services
- Nutritional Counseling

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

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

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a

Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

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

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

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an exception to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and

b. a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or

b. the mother must request the in-patient care.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

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

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

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

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, in addition to the Cash Deductible, any other Co-Payments, and Co-Insurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

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

EXHIBIT E

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN E]

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

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

Medicare Alternate Deductible

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

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

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

Co-Insurance Caps

Per Covered Person per each Calendar Year	$1,500
Per Covered Family per each Calendar Year	$3,000 [**Note:** Must be individually satisfied by 2 separate Covered Persons]

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

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

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

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

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

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

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [• Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer.]
- Fertility Services
- Nutritional Counseling

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

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

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

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

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

As an exception to the Medically Necessary and Appropriate requirement of this Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and

b. a minimum of 96 hours of in-patient Hospital care following cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or

b. the mother must request the in-patient care.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

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

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

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

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, in addition to the Cash Deductible, and other Co-Payments, and Co-Insurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

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

EXHIBIT F

PLANS B, C, D, E

[Carrier]

SMALL GROUP HEALTH BENEFITS POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER

[G–12345]

GOVERNING JURISDICTION

NEW JERSEY

EFFECTIVE DATE OF POLICY

[January 1, 1996]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1997]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1996]

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

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

[Secretary President]
[Dividends are apportioned each year.]

POLICY INDEX

SECTION	PAGE(S)
Schedule of Insurance and Premium Rates	
General Provisions	
Claim Provisions	
Planholders	
Definitions	
Employee Coverage	
[Dependent Coverage]	
[Preferred Provider Organization Provisions]	
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[Grievance Procedure]	
Health Benefits Insurance	
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Exclusions	
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Effect of Interaction with a Health Maintenance Organization Plan	
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Medicare as Secondary Payor	
Right to Recovery—Third Party Liability	
Statement of ERISA Rights	
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SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (WITHOUT CO-PAYMENT)**

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be

individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

The **Co-Insurance** for this Policy is as follows:	
• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES — **EXAMPLE PPO (with Co-payment)**

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

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year
Calendar Year Cash Deductible—If treatment services or supplies are given by an Out-Network Provider	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

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

The **Co-Insurance** for this Policy is as follows:	
• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by an Out-Network Provider	30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE POS**

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

CLASS

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given or referred by a PCP:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year
Calendar Year Cash Deductible—If treatment services or supplies are given by a Non-referred Provider	
Per Covered Person	[$250, $500 or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

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

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

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

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

The Co-Insurance for this Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, except as stated below
• if treatment, services or supplies are given or referred by a non-referred Provider	20%, except as stated below
Exception: for Mental and Nervous and Substance Abuse charges	
• if treatment, services or supplies are given or referred by the PCP	0%
• if treatment, services or supplies are given by a non-referred Provider	25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required, except as stated below.

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

PPO/POS USING PLAN B

Daily Room and Board Limits

• During a Period of Hospital Confinement

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

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

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

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

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

PPO/POS USING PLANS C, D, E

Daily Room and Board Limits

• During a Period of Hospital Confinement

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

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

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

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

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits

Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	Premium Rate
Health Benefits	
—per Employee	$9999.99]
[—per Employee and spouse	$9999.99
—per Employee and children	$9999.99
—per Employee, spouse and children	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;

b.] the Policyholder's application, a copy of which is attached to this Policy;

[c.] any riders, [endorsements] or amendments to this Policy and

[d.]the individual applications, if any, of the persons covered.

STATEMENTS

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or

b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

AMENDMENT

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this

Policy on or after the Effective Date of such change.

[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

AFFILIATED COMPANIES

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees [and Dependents] then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee [and/or Dependent] whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's [and/or Dependent's] coverage has ended.
b. The amount of any claims paid to an Employee for the Employee's claims [or to a member of the Employee's family unit] after that person's coverage has ended.]

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents]. One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date as shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
   - by amendment or this Policy; or
   - by reason of any provision of law or any government program or regulation; or
   - if this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

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

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

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

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

CLERICAL ERROR—MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will not invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

TERMINATION OF THE POLICY-RENEWAL PRIVILEGE

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period-Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.
b. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
c. with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

d. with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under any Health Benefits Plan offered by the Policyholder,

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

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

This Policy is issued for a term of one (1) year from the Effective Date shown in the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:01 a.m. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer in accordance with the laws in the State of New Jersey.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains

the right to take the action described above as of the Employer's Policy Anniversary.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,
(2) any protection and rights when the coverage ends and
(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

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

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS-INFORMATION TO BE FURNISHED

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee [and Dependents] eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee [or Dependent] coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage should have ended.]

CLAIMS PROVISIONS

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

[NOTICE OF LOSS

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

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

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

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET).]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this Policy for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note:** The Emergency Room Co-Payment, if applicable, must be paid in addition to the Cash Deductible, any other Co-Payments, and Co-Insurance.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Coverage Charges** and **Covered Charges With Special Limitations** section of this Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an Eligible Employee [or a Dependent] who is insured under this Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means an Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[Dependent's Eligibility Date means the later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

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

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee [or Dependent,] as the context in which the term is used suggests.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy.

Employee's Eligibility Date means the later of:

a. the date of employment; or

b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

[**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

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

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

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks,

strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs; and
f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

Mental Health Center means a Facility which mainly provide treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission;
b. approved for its stated purpose by Medicare; or
c. accredited or licensed by the state of New Jersey to provide mental health services.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

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

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

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Reasonable and Customary means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

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

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

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

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

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are

employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

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

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

Substance Abuse means abuse of or addiction to drugs.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means:

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

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

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

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

[**You, Your and Yours** mean the Employer.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of this Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

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

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility, which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of an Employee's coverage.

When Employee Coverage Ends

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Policy.
c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are the Employees:

a. legal spouse;
b. unmarried Dependent children who are under age 19; and
c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children,
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption.

[Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and this Policy, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Policy's age limit;

b. the child became insured by this Policy or any other policy before the child reached the age limit, and stayed continuously insured after reaching such limit; and

c. the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and

b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the exception stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the Dependent's Eligibility Date, or

b. the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the Dependent's Eligibility Date for the newly Acquired Dependent.

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

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under this Policy will end on the first of the following dates:

a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.
b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c. ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d. ***Out-Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services

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

Emergency Services

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

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

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

Utilization Review

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is offered as POS.]

[Grievance Procedure: Carrier may elect to include a grievance procedure when the plans are issued including Preferred Provider Organization of Point of Service Provisions. If a Carrier has had a Selective Contracting Arrangement approved by the New Jersey Departments of Insurance and Health it may include that approved Grievance Procedure language in the standard SEH forms.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or limited if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

[Family Deductible Limit

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.]

[Per Covered Family

The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the Per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Co-Insurance Cap

This Policy limits Co-Insurance amounts each Calendar Year except as stated below. The Co-Insurance Cap cannot be met with

a. Non-Covered Charges;
b. Cash Deductibles;
c. Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse; and
d. Co-Payments.

There are Co-Insurance Caps for:

a. each Covered Person; and
b. each Covered Family.

The Co-Insurance Caps are shown in the Schedule.

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

[Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.]

[Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Co-Insurance Caps equal to the Per Covered Family Co-Insurance Cap, each Covered Person in that family will be considered to have met his or her Per Covered Person Co-Insurance Cap for the rest of that Calendar Year.]

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Co-Insurance Cap.]

[Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required, except as stated below.

Exception: Charges for Mental and Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the Coinsured Charge Limit.]

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by two or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. The Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. this Policy starts right after the old plan ends.

Extended Health Benefits

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar year. Charges for any additional days are a Non-Covered Charge.

But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges

Subject to [Carrier's] Pre-Approval, when home health care can take the place of inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
      - ordered by the Covered Person's Practitioner;
      - included in the home health care plan; and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

   c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.
   d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   e. [Carrier] does not pay for:
      - services furnished to family members, other than the patient; or
      - services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse

[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:

a. a Hospital;
b. a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c. a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

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

Birthing Center Charges

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

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

[Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

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

Anesthetics and Other Services and Supplies

[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood

[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a. a local Hospital if needed care and treatment can be provided by a local Hospital;
b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c. transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients. Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:

a. any purchases without [Carrier's] advance written approval;
b. replacements or repairs; or
c. the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor

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

Nutritional Counseling

Subject to [Carrier] Pre-Approval, [Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner. Charges for Nutritional Counseling which are not Pre-Approved by [Carrier] are Non-Covered Charges.

X-Rays and Laboratory Tests

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's **Preventive Care** section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

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

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

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

In no event will [Carrier] pay for:

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

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

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of this Policy.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment

[Carrier] covers:

a. the diagnosis and treatment of oral tumors and cysts; and
b. the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is insured under any health benefit plan;
b. the Injury was not caused, directly or indirectly by biting or chewing; and

c. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

[Carrier] will cover charges for:

a. one baseline mammogram for a female Covered Person, ages 35–39
b. one mammogram, every 2 years, for a female Covered Person, ages 40–49, or more frequently, if recommended by a Practitioner, and
c. one mammogram, every year, for a female Covered Person ages 50 and older.

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

Pre-Existing Conditions

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

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

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

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

[This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And] [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based, self-funded or other health benefit arrangement, prior to enrollment under this Policy. When this happens, if the previous plan provided coverage for a condition [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing, whether or not the previous plan paid benefits for the condition to the Covered Person. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment*—the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
g. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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

h. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
i. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy*—subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Fertility Services

Subject to [Carrier] Pre-Approval [Carrier] covers charges for procedures and prescription drugs to enhance fertility. Charges in connection with Fertility Services which are not Pre-Approved by [Carrier] or which are specifically excluded are Non-Covered Charges.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to:

a. $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b. $300 per Covered Person for all other Covered Persons.

These changes are not subject to the Cash Deductibles or Co-Insurance.

Therapeutic Manipulation

[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. [Carrier] includes a condition under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered charges for the treatment of Mental and Nervous conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Co-Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

[Vision Screening

[Carrier] covers eye examinations for Dependent children, through age 17, to determine the need for vision correction.]

Transplant Benefits

[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a. Cornea
b. Kidney
c. Lung
d. Liver
e. Heart
f. Pancreas
g. Allogenic Bone Marrow
[h. Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  —SCID
  —WISCOT Alldrich
- Subject to [Carrier] Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by [Carrier] are Non-Covered Charges.**]

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

IMPORTANT NOTICE

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

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

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

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

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

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

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required

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

Pre-Hospital Review

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

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

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

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

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

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admis-

sion. This must be done at the time [ABC] is notified of such admission.

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

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

In case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

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

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

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

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

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

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

Pre-Hospital Review

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

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%**] if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: *No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].*

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

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

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner;

- Covered Person;
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: *No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.*

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

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

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

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

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

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

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

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an Illness or Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

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

Dental care or treatment, including appliances, except as otherwise stated in this Policy.

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

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

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

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

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

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygot Intra-fallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

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

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

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

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

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

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

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

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services*** except as otherwise stated in this Policy.

Supplies related to ***Methadone*** maintenance.

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

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

Non-prescription drugs or supplies, except

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

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

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

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

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

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

Services or supplies related to ***Routine Foot Care,*** except:

a. an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b. the removal of nail roots; and
c. treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

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

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.
e. provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
   - [Subject to Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Stand-by services required by a Provider.

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

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

Telephone consultations.

Transplants, except as otherwise listed in this Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUING RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or

c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act.
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If An Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefits plan for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying;
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:

- **the Employer must allow for a leave of absence under Federal law in which case;**
- **the section applies to the Employee.**

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-time work;
b. the end of a total leave period of 12 weeks in any 12 month period;
c. the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d. the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or
b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:

IF: on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

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

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made at any other time

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

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

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in this policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law; or
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorce parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
   - When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
   - If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
   - The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily injury sustained by a Covered Person as a result of an accident.

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for One Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or SAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

Medicare

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

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

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

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

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

With respect to the following provisions:

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

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

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

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

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

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

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary

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

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of disability.

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

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare

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

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

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

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

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

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary plan. This Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

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

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
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).

EXHIBIT G

HMO PLAN

[Carrier]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT

CONTRACT HOLDER: [ABC Company]

GROUP CONTRACT NUMBER

[G–12345]

GOVERNING JURISDICTION

NEW JERSEY

EFFECTIVE DATE OF CONTRACT

[January 1, 1996]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 1997]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1996]

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

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

[Secretary President]

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I. SCHEDULE OF PREMIUM RATES

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

Subscriber Only .....$]

[Subscriber and Spouse .....$
Subscriber and Child(ren) .....$
Subscriber and Family .....$

(including Subscriber, spouse and one or more eligible dependents)]

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

II. SCHEDULE OF SERVICES

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES—COPAYMENTS]:

HOSPITAL SERVICES:

INPATIENT

$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.

OUTPATIENT

$15 Copayment/visit

DOCTOR SERVICES RECEIVED AT A HOSPITAL:

INPATIENT

None

OUTPATIENT

$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM

$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)

OUTPATIENT SURGERY

$15 Copayment/visit.

HOME HEALTH CARE

Unlimited days, if preapproved.

HOSPICE SERVICES

Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE)

$25 Copayment for initial visit only.

MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT

$15 Copayment/visit; maximum 20 visits/Calendar Year.

INPATIENT

$150 Copayment/day for a maximum of 5 days per admission.

Maximum Copayment $1,500/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION

$15 Copayment/visit; maximum 30 visits/Calendar Year.

PODIATRIC

$15 Copayment/visit (excludes Routine Foot Care).

PRE-ADMISSION TESTING

$15 Copayment/visit.

PRESCRIPTION DRUG

50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES

$15 Copayment/visit.

PRIMARY CARE SERVICES

$15 Copayment/visit.

REHABILITATION SERVICES

Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.

SECOND SURGICAL OPINION

$15 Copayment/visit.

SPECIALIST SERVICES

$15 Copayment/visit.

SKILLED NURSING CENTER

Unlimited days, if preapproved.

THERAPY SERVICES

$15 Copayment/visit.

DIAGNOSTIC SERVICES (OUTPATIENT)

$15 Copayment/visit.

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

III. DEFINITIONS

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

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

ALCOHOL ABUSE. Abuse of or addiction of alcohol.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

[**COINSURANCE.** The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier].

CONTRACT HOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies. **Note:** The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Contract.

Read the entire Contract to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

a. is furnished mainly to help Member meet Member's routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

[**DEPENDENT.**

An Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section of this Contract.

An Employee's "unmarried Dependent child" includes his or her legally adopted child, his or her step-child if such step child depends on the Employee for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is insured by this Contract as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.]

[**DEPENDENT'S ELIGIBILITY DATE.**

The later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent]

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a. radiology, ultrasound, and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION. Our sole right to make a decision or determination.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

a. designed and able to withstand repeated use;
b. used primarily and customarily for a medical purpose;
c. is generally not useful to a Member in the absence of an Illness or Injury; and
d. suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Employer, or the date coverage begins under this Contract for a Member, as the context in which the term is used suggests.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a. the date of employment; or
b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   I. The American Medical Association Drug Evaluations;
   II. The American Hospital Formulary Service Drug Information; or
   III. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be approved for its stated purpose by Medicare; or
b. be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be accredited as a hospital by the Joint Commission, or
b. be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member. A Mental or Nervous Condition is not an illness.

[**INITIAL DEPENDENT.** Those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

INJURY. Damage to a Member's body due to accident, and all complications arising from that damage.

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

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

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

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include but are not limited to heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for a Member's convenience;
e. the most appropriate level of medical care that a Member needs; and
f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

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

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission;
b. approved for its stated purpose by Medicare; or
c. accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personally disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

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

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

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

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b. provides medical services which are within the scope of the nurse's license or certificate and are covered by this Contract.

OUTPATIENT. Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

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

PRACTITIONER. A medical practitioner who:

a. is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b. provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

[**PRE-EXISTING CONDITION.** An Illness or Injury which manifests itself in the six months before a Member's coverage under this Contract starts, and for which:

a. a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

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

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

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

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE and CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician in conformance with our policies and procedures that directs a Member to a facility or Provider for health care.

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

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

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

SERVICE AREA. A geographic area We defined by [ZIP codes] [county].

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

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

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

SMALL EMPLOYER. Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

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

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

SUBSCRIBER. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

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

b. be approved for its stated purpose by Medicare.

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

SURGERY.

a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;

b. the correction of fractures and dislocations; or

c. pre-operative and post-operative care.

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

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

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

IV. ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Contract, all of the Contract Holder's Employees [who are in an eligible class] and who reside in the Service Area will be eligible if the Employees are Actively at Work Full-Time Employees.

For the purpose of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's Conditions of Eligibility.

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not cover an Employee unless the Employee is an Actively at work Full-Time Employee.

Enrollment Requirement

We will not cover the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage will start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under his Contract, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But the Employee must enroll under this Contract within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

The Employer who purchased this Contract may have purchased it to replace a plan the Employer had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. this Contract starts right after the old plan ends.

Multiple Employment

If an Employee works for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Contract.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of an Employee's coverage.

When Employee Coverage Ends

An Employee's coverage under this Contract will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Contract.
c. the date this Contract ends, [or is discontinued for a class of Employees to which the Employee belongs.]
d. [the date] for which required payments are not made for the Employee.

[e. [the date] an Employee moves his or her permanent residence outside the Service Area.]

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Contract's benefits provisions explain these situations. Read this Contract's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

[Except as stated below, an] Employee's eligible Dependents are:

a. the Employee's legal spouse;
b. the Employee's unmarried Dependent children who are under age 19; and
c. the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children and Step-Children

An Employee's "unmarried Dependent children" include the Employee's legally adopted children, his or her step-children if they depend on the Employee for most of their support and maintenance and children under a court-appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by this Contract as an Employee or
b. on active duty in the armed forces of any country.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Contract's age limit; and
b. the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is handicapped and depends on the Employee for most support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the exception stated below and to all of the terms of this Contract, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents [and agrees to make any required payments].

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the Dependent's eligibility date, or
b. the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee, the coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes covered for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a. the date the Employee notifies [Carrier] [and agrees to make any additional payments], or
b. the Dependent's Eligibility Date for the Newly Acquired Dependent is first eligible.

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

Newborn Children

We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child[; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.]

If the request is not made[and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's coverage under this Contract will end on the first of the following dates:

a. [the date] Employee coverage ends;
[b. the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c.] the date this Contract ends;
[d.] the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f.] At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.
[g.] the date the Dependent moves his or her permanent residence outside the Service Area.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If this Contract ends and a Member is Totally Disabled and under a Practitioner's care, We will extend health

benefits for that person under this Contract as explained below. This is done at no cost to the Member.

We will only extend benefits for a Member due to the disabling condition. The charges must be incurred before the extension ends. And what We pay is based on all the terms of this Contract.

We do not pay for charges due to other conditions. And, We do not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends;
b. one year from the date the person's coverage under this Contract ends; or
c. the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under this Contract:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.

(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use an identification card We issue to the Member.

(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.

(5) **Misconduct:** The Member abuses the system, including but not limited to; theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.

(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and
(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

V. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

a. **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:
   1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
   2. **Home visits** by a Member's Primary Care Physician.
   3. **Periodic health examinations** to include:
      a. Well child care from birth including immunizations;
      b. Routine physical examinations, including eye examinations to determine the need for vision correction;
      c. Routine gynecologic exams and related services;
      d. Routine ear and hearing examination; and
      e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
   4. **Diagnostic Services.**
   5. **Casts and dressings.**
   6. **Ambulance Service** when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
   7. Procedures and prescription drugs to enhance **fertility**, except where specifically excluded in this Contract.
   8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.

9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
10. **Prescription Drugs and contraceptives** which require a Practitioner's prescription and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.
11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Member's Primary Care Physician and approved in advance by Us.
12. Dental x-rays when related to Covered Services.
13. Oral surgery in connection with bone fractures, removal of tumors and orthodontic cysts, and other surgical procedures, as We approve.

b. **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician.

c. **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval:

1. Semi-private room and board accommodations

   As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

   a. up to 48 hours of in-patient care in a Participating Hospital following a vaginal delivery; and
   b. a minimum of 96 hours of in-patient care in a Participating Hospital following a cesarean section.

   We provide such coverage subject to the following:

   a. the attending Practitioner must determine that in-patient care is medically necessary; or
   b. the mother must request the in-patient care.

2. Private accommodations. If a Member occupies a private room without such certification Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or the Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre-and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
22. Allogeneic bone marrow transplants

[23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

d. **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health

Center] upon prior written referral by a Member's Primary Care Physician.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Chemical Dependency Admissions. Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.
3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

e. **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
   a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-emergency basis; and
   c. We and a Member's Primary care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event Members are hospitalized in a Nonparticipating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Nonparticipating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

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

4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Member shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

f. **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.
1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy Treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

g. **HOME HEALTH SERVICES.** The following Services are covered when rendered by a Participating Provider including but not limited to a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.
1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members; inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate Care.

VI. NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

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

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

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

Completion of claim forms.

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Contract, unless it is required as a result of an Illness or Injury sustained while covered under this Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

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

Dental care or treatment, including appliances, except as otherwise stated in this Contract. **Care or treatment by means of dose intensive chemotherapy, except as otherwise stated in this Contract.**

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

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

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

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

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:

a. procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygotr Intra-fallopian Transfer (ZIFT); and
b. drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, services or supplies related to **Hearing aids** and **hearing examinations** to determine the need for hearing aids or the need to adjust them.

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

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Contract.

Services or supplies related to **Hypnotism.**

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

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

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

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

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

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[**Pre-Existing Condition Limitations:** We do not cover services for Pre-Existing Conditions until Members have been covered by this Contract for six months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child.

A new Member may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based, self-funded or other health benefit arrangement, prior to enrollment under this Contract. When this happens, if the previous plan provided coverage for a condition, we give credit for the time he or she was covered under the previous plan to determine if the condition is Pre-Existing whether or not the previous plan paid benefits for the condition to the Member. We go back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Contract starts is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, and Employee must still meet it before becoming covered.]

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Contract.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

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

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

Services or supplies related to **Routine Foot Care**, except:

a. an open cutting operation to treat weak, strained, flat, unstable or unbalanced fee, metatarsalgia or bunions;
b. the removal of nail roots; and
c. treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:

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

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

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

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a war, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

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

VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VIII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance coverages; nor
e. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first or provides services, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a. A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d. For a Dependent child of separated or divorced parents, the following governs which plans pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a. this Contract;
b. PIP; or
c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contract Holder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

The rules of the COORDINATION OF BENEFITS AND SERVICES section of this Contract will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the equivalent value of services if this Contract had been primary.

IX. CONTRACT HOLDER GENERAL PROVISIONS

AMENDMENTS

The Contract may be amended, at any time, without a Member's consent or that of anyone else with a beneficial interest in it. The Contract Holder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contract Holder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a. it is shown in an endorsement on it signed by one of Our officers.

b. if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called "Conformity With Law," it is shown in an amendment to it that is signed by one of Our officers.

c. if a change is required by Us, it is accepted by the Contract Holder, as evidenced by payment of a Premium on or after the effective date of such change.

d. if a written request for a change is made by the Contract Holder, it is shown in an amendment to it signed by the Contract Holder and by one of Our Officers.

ASSIGNMENT

No assignment or transfer by the Contract Holder of any of the Contract Holder's interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Contract will reduce a Member's Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

CONFORMITY WITH LAW

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONTRACT INTERPRETATION

We shall administer Contract in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

[CONVERSION PRIVILEGE

If an Employee's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.]

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with Fraudulent statements.

If this Contract replaces the contract of another insurer or carrier, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to the Contract Holder: To the last address provided by the Contract Holder on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Contract Holder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplication of it is attached to this Contract or has been furnished to the Contract Holder for attachment to this Contract.

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect and the Employees then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Contract Holder and Us.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

a. the amounts of the Premium charges for the Member that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contract Holder that the Member's coverage has ended.
b. the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Contract Holder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contract Holder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contract Holder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to change Premium rates as of any of these dates:

a. any Premium Due Date;
b. any date that an Employer becomes, or ceases to be, an Affiliated Company;
c. any date that the extent or nature of the risk under the Contract is changed:
   1. by amendment of the Contract; or
   2. by reason of any provision of law or any government program or regulation;
d. at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE

We have the right to cancel this Contract on any premium due date subject to 30 days advance written notice to the Contract Holder for the following reasons:

a. During or End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. But the Contract Holder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested.
b. the Contract Holder moves its principal place of business outside the State of New Jersey;
c. subject to the statutory notification requirements, We cease to do business in the small group market;
d. with respect to Contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate Health Benefits Plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e. with respect to Non-contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate Health Benefits Plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.)

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

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. All periods of coverage hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Contract Holder's place of business.

The Contract Holder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on any Contract Anniversary if the Contract Holder is no longer a Small Employer.

The Employer must certify to Us the Employer's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Employer fails to do this, We retain the right to take the actions described above as of the Employer's Contract Anniversary.

THE CONTRACT

The entire Contract consists of:

[a. the forms shown in the Table of Contents as of the Effective Date;

b.] the Contract Holder's application, a copy of which is attached to the Contract;

[c.] any riders, [endorsements] or amendments to the Contract; and

[d.] the individual applications, if any, of all Members.

X. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Contract is valid unless We consent thereto.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

[CONVERSION PRIVILEGE

If a Subscriber's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.]

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If this Contract replaces the contract of another insurer or carrier, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.
2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Contract.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Member's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been mailed to a Member for attachment to this Contract.

CONTRACT INTERPRETATION

We shall administer Contracts in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including but not limited to Specialist Services) if a Member has not been referred by his or her Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of a Member's records by us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The member can select another Primary Care Physician from Our [Physician or Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

STATEMENTS

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

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If an Employee fails to pay the cost of Dependent coverage, an Employee's Dependent coverage will end. It will end on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he attains the Contract's age limit, or marries, or when a step-child is no longer dependent on the Employee for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

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

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when a Member needs treatment for one of these conditions.]

XI. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a Member is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a Member elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

When covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subjected to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered

If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to the **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Contract's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Contract ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Contract's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed covered under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first,

will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof for insurability in order for an Employee to continue.

When Continuation Ends

A Member's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Member becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;

e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying;

b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence under Federal law and, therefore
- the section applies to the Employee.

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a. the date the Employee returns to Full-Time work
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this contract may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been covered under this Contract for at least 3 months.
- if he or she is eligible for Medicare;
- if it would cause him or her to be excessively covered; or
- [• if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if excessive coverage exists using Our standards for excessive coverage.

HOW AND WHEN TO CONVERT

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

THE CONVERTED CONTRACT

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

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

XII. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health bene-

fits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

XIII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

1. In the case of an Employee, the Employee is not retired.
2. In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.
3. The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.

For a member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

1. The Member, if eligible, has enrolled in Parts A and B of Medicare.
2. The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES.

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
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).

EXHIBIT H

PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD/MAIL)**

Policyholder:

Group Policy No.:

Effective Date:

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

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;

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

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

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

In no event will [Carrier] pay for:

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

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

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 or Mental and Nervous Conditions and Substance Abuse;

Such charges will not include charges made for more than:

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

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

POLICYHOLDER LIABILITY

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

EXCLUSIONS

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

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

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs 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).

EXHIBIT H

PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD)**

Policyholder:

Group Policy No.:

Effective Date:

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

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

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

In no event will [Carrier] pay for:

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

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

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 of concentration, dosage form and route of administration.

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

Prescription Drug means:

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

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

CO-PAYMENT

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

• for Generic Drugs	$5.00
• for Brand Name Drugs	$10.00

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

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

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

Such charges will not include charges made for more than:

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

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

POLICYHOLDER LIABILITY

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

EXCLUSIONS

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

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

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs 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).

EXHIBIT H

PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE **(MAIL)**

Policyholder:

Group Policy No.:

Effective Date:

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

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

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

In no event will [Carrier] pay for:

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

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

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 or Mental and Nervous Conditions and Substance Abuse

Such charges will not include charges made for more than:

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

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

POLICYHOLDER LIABILITY

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

EXCLUSIONS

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

a. Charges to administer a Prescription Drug.
b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs 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).

EXHIBIT I

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:

Group Policy No:

Effective Date:

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

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

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

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

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use";

or

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

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

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

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

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

PRE-CERTIFICATION REQUIREMENTS

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

NON-EMERGENCY SITUATIONS

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

EMERGENCY SITUATIONS

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

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

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

a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15] to the [XYZ] referred provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a. 30 days of Inpatient care per Calendar year; and
b. 20 Outpatient visits per Calendar year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;
b. the Covered Person's treatment does not comply with the treatment plan;
c. the Covered Person goes to a provider whose services were not referred by [XYZ]; or
d. [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

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

[Carrier should insert Standard Rider Closure.]

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).

EXHIBIT J

PART 1

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

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

In no event will We provide [or arrange] for

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

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

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

Generic Drugs mean:

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

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

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

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

Prescription Drug means:

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

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

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:

• for Generic Drugs	$5.00
• for Brand Name Drugs	$10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin)
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends, except as stated in the Extended Health Benefit section of the Contract.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs for the management of nicotine dependence.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r. Drugs needed due to an on-the-job -related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

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

[Carrier should insert Standard Rider]

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT J

PART 2

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

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

In no event will We provide [or arrange] for

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

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, and contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

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

Generic Drugs mean:

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

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

Prescription Drug means:

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

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

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

• for Generic Drugs	$5.00
• for Brand Name Drugs	$10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs for the management of nicotine dependence.
m. Topical dental Fluorides.

n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

p. Drugs dispensed to a Member while on active duty in any armed force.

q. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r. Drugs needed due to an on-the-job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

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

[Carrier should insert Standard Rider]

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT J

PART 3

RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

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

In no event will We provide [or arrange] for

a. drugs labeled: "Caution-limited by Federal Law to Investigational Use"; or

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

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

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

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

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

Prescription Drug means:

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

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

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin)
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance Drug; and
b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution-limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   • a Hospital
   • a rest home
   • a sanitarium
   • a Skilled Nursing Center
   • a Substance Abuse Center
   • an alcohol abuse or mental health center
   • a convalescent home
   • a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs for the management of nicotine dependence.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r. Drugs needed due to an on-the-job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

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

[Carrier should insert Standard Rider]

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).

EXHIBIT K

PART 1

EXPLANATION OF BRACKETS—POLICY FORMS

(PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in five ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.
e. Some areas of variability are determined by the election made by a Carrier, or by the delivery system.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the policy forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The **BENEFIT PROVISION** of the **HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule.** NOTE: ALL plans issued by a Carrier MUST include the same option.
4. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
5. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy-Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
8. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
9. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
10. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
11. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
12. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE: A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.**
13. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.
14. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.

15. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

(RIDERS)

All text which is enclosed in brackets [ ] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The Appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

EXHIBIT K

PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract forms.

1. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
2. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.
3. The Generic Drug definition can be deleted if not needed.
4. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE: ALL plans issued by a Carrier must make the optional benefit available in the same manner.**
5. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
6. OB/GYNs can be considered Primary Care Physicians.
7. Eligible class references can be removed.
8. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
9. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
10. Small Claims Waiver can be deleted.
11. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy-Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
12. Transfer of Primary Care Physician can occur according to carrier administration.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

EXHIBIT L

PART 1

PATIENT INSTRUCTIONS FOR HCFA 1500

To request reimbursement for medical expenses; please complete the attached form blocks 1 through 13. To assist you, follow the instructions below. Please remember that all statements must be accurate.

Please bring this claim form with you at the time the medical services are rendered. The provider of service is responsible for completing blocks 14 through 33.

When requesting reimbursement, you should also attach copies of itemized bills and receipts for the medical services for which you are submitting a claim.

PATIENT INSTRUCTIONS

Block 1

Place an "X" in the appropriate block which identifies the type of insurance program that applies to the claim.

Block 1a

Enter the Social Security number or unique identification number assigned by the insurance carrier or the individual in whose name the insurance is carried.

Block 2

Enter the patient's last name, first name and middle initial.

Block 3

Enter the patient's date of birth in a MMDDYY format. Example: 01 12 94 for January 12, 1994. Place an "X" in the appropriate gender box.

Block 4

Enter the last name, first name and middle initial of the individual in whose name the insurance is carried.

Block 5

Enter the mailing address of the patient.

Block 6

Place an "X" in the appropriate box which identifies the relationship of the patient to the insured individual.

Block 7

Enter the mailing address of the individual who holds the insurance if it is different from the patient's address listed in Block 5. Otherwise, enter the word "SAME".

Block 8

Place an "X" in the appropriate box which identifies the patient's marital status. Also, place an "X" in the appropriate box which identifies the employment/student status of the patient.

Block 9

If the patient has other insurance, enter the last name, first name and middle initial of the covered individual if it is different from that shown in Block 4. Otherwise, enter the word SAME.

Block 9a

Enter the other insurance carrier's identification number or unique code assigned by the carrier to identify the group or policy under which the individual in Block 9 is covered.

Block 9b

Enter the date of birth or the individual (listed in Block 9) in a MMDDYY format. Example: 011294 for January 12, 1994.

Enter an "X" in the appropriate gender box.

Block 9c

Enter the name of the individual's (listed in Block 9) employer or school name.

Block 9d

Enter the name of the insurance program covering the individual in Block 9.

Block 10a through 10c

Place an "X" in the appropriate box to indicate whether the patient's condition is related to employment, auto accident, or other accident. For auto accidents, indicate the states' abbreviation in which the accident occurred (e.g. New Jersey—NJ).

Block 10d

This field is not required.

Block 11

Enter the identification or unique code assigned by the carrier to identify the group or policy under which the individual is covered.

Block 11a

Enter the individual's (listed in Block 4) birthdate in a MMDDYY format. Example: 011294 represents January 12, 1994.

Place an "X" in the appropriate gender box.

Block 11b

Enter the individual's (listed in Block 4) **employer name or school name.**

Block 11c

Enter the name of the insurance program covering the individual in Block 4.

Block 11d

Place an "X" in the appropriate box. If the answer is YES, complete sections 9a–9d.

Block 12

The patient's signature in this field authorizes release of medical information necessary to process this claim. The patient or an authorized representative should sign and date this block unless the signature is on file in the provider's office/facility.

Block 13

The signature in this block authorizes the insurance carrier to release insurance benefits directly to the provider of the services listed in Block 33.

Exhibit L, Part 2

APPROVED OMB NO. 0938-0279

	2				3 PATIENT CONTROL NO.				4 TYPE OF BILL	
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11		
12 PATIENT NAME		13 PATIENT ADDRESS								
14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES 25 26 27 28 29 30 31
32 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN CODE FROM THROUGH		37 A B C				
38		39 VALUE CODES CODE AMOUNT				41 VALUE CODES CODE AMOUNT				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
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	50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A							
B							
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG CO	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P C	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID	a
					b
	OTHER PROCEDURE CODE DATE			83 OTHER PHYS. ID	a
					b
a	84 REMARKS			OTHER PHYS. ID	a
b					b
c				85 PROVIDER REPRESENTATIVE	86 DATE
d				X	

UB-92 HCFA-1450 **OCR/ORIGINAL**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, members of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

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

EXHIBIT M

Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

GE 0094
Annual Family Profile and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

Employer name	Employer phone number	Plan/Policy Number

Check one ☐ Active employee ☐ Retired employee ☐ Continued individual

Employee information

Name	Date of birth	Social Security Number

Address	City	State	ZIP	Home phone number

Do you have another employer? ☐Yes ☐No	If "Yes," please give name of other employer	Other employer's phone number

Are you covered by another group plan? ☐Yes ☐No	If "Yes," please give name of carrier	Plan number	Other carrier's phone number

Spouse information

Name	Date of birth	Social Security Number

Name and address of spouse's employer	Phone number of spouse's employer

Is spouse covered by another group plan? ☐Yes ☐No	If "Yes," please give name of other carrier	Plan number	Other carrier's phone number

Dependent children information

Name	Date of birth ☐Male ☐Female	Social Security No.	Relation to employee	Handicapped ☐Yes ☐No

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

Name	Name of school	Address of school

If any child is covered by another group plan, please give the information requested below.

Name	Insured person	Name of carrier	Plan number

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

Signature of employee _____ Signature of patient if other than minor child _____ Date _____

SEH-FP-7/93

EXHIBIT N

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type

Policy number: ([Carrier] Use Only)

☐ New Policy ☐ Change in Policy

Requested Effective Date:_____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company):_____
2. Tax Identification Number:_____
3. Main Address:_____
   Street *City* *State* *Zip*

   Mailing Address:_____
   Street *City* *State* *Zip*

   Telephone: ( )_____ Fascimile: ( )_____
4. Name of Correspondent:_____ Title:_____
5. Type of organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):_____
6. Nature of business (specify):_____ SIC Code_____
7. Number of eligible employees in your company:_____

   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee
8. Number of eligible employees to be insured:_____
9. Class or classes to be excluded:_____
10. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents
11. Are you subject to the requirements of COBRA? ☐ Yes ☐No
12. Waiting period before employees become insured: (may not exceed 6 months)
    Present employees: _____ New Employees _____
13. What percentage of the premium will the employer pay? _____
14. Deposit $_____

Premium Paid: ☐ Monthly ☐ Quarterly [☐ Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible ees in this company	No. eligible ees to be insured	[Type of organization]	[Nature of business]

ible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

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

Co-Insurance

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

The Co-Insurance for the Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

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

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

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

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

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Fertility Services

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

SCHEDULE OF INSURANCE EXAMPLE: PLAN A PPO

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

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

Medicare Alternate Deductible

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

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

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

Co-Insurance

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

	If treatment, services or supplies are given by: *a Network Provider*	*an Out-Network Provider*
The Co-Insurance for the Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each calendar year** before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

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

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

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

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

[Carrier] will cover the lesser of:

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

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- **Fertility Services**

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

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis* for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis* for Hospital days
Charges for Hospice Care	exchange basis* for Hospital days

* See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
[—per Covered Family	$300]
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

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

[NOTICE OF LOSS

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

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

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

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout the [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does

not include Cash Deductibles, Co-Payments or Non-Covered Charges.

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

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an Eligible Employee [or a Dependent] who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means Your:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:

a. Your legally adopted children.
b. Your step-children if such step-children depend on You for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

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

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee [or Dependent].

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

[**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

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

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

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs;
f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods of psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

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

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

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

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

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

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

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

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

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

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

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

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

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

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

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

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

b. approved for its stated purpose by Medicare.

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

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

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

Schedule means the Schedule of Insurance contained in the Policy and in this [certificate].

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

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

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means:

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

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

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

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

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

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

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

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under the Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the date after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your Coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:

a. [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] You stop being an eligible Employee under the Policy.
c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.
d. the last day of the period for which required payments are made for You.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your Eligible Dependents are Your:

a. legal spouse;
b. unmarried Dependent children who are under age 19; and
c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this [certificate].

Your "unmarried Dependent child" includes:

a. Your legally adopted children,
b. Your step-children if such step-children depend on You for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached the Policy's age limit;
b. the child became insured by the Policy or any other policy before the child reached the age limit, and stayed continuously insured after reaching such limit; and
c. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of Your spouse; or

d. termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the exception stated below and to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or

b. the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or

b. the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date You notify [Carrier] and agree to make any additional payments, or

b. the Dependent's Eligibility Date for the newly Acquired Dependent.

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

Newborn Children

[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

b. If You are not covered for Dependent child coverage on the date the child is born, then You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under the Policy will end on the first of the following dates:

a. [the date] Your coverage ends;
b. the date You stop being a member of a class of Employees eligible for such coverage;
c. the date the Policy ends;
d. the date Dependent coverage is terminated from the Policy for all Employees or for Your class;
e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons;
f. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.]

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. *Primary Care Practitioner* (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

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

c. *Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. *Out-Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. *Service Area* means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without referral from her PCP. She must obtain authorization from her PCP for other services.

Out-Network Services

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

Emergency Services

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

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

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

Utilization Review

The Policy has utilization features. See the Utilization Review Features section of this [certificate].

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note:** Used only if coverage is issued as POS.]

[Grievance Procedure: Carrier may elect to include a grievance procedure when the plans are issued including Preferred Provider Organization of Point of Service Provisions. If a Carrier has had a Selective Contracting Arrangement approved by the New Jersey Departments of Insurance and Health it may include that approved Grievance Procedure language in the standard SEH forms.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or limited if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

[Family Deductible Limit

The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the

rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.]

[Per Covered Family

The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the Per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Co-Insurance Cap

The Policy limits Co-Insurance amounts each Calendar Year except as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles; and
c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.]

[Coinsured Charge Limit

The coinsured charge limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required.]

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;
b. The Policy would have paid benefits for the charges, if the Policy had been in effect;
c. The Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and
d. The Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy the Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. the Policy starts right after the old plan ends.

Extended Health Benefits

If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under the Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Charges while Hospitalized

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board
b. Routine Nursing Care
c. Prescription Drugs
d. Blood transfusions
e. Infusion Therapy
f. Chemotherapy
g. Radiation Therapy
h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

As an exception to the Medically Necessary and Appropriate requirement of the Policy, [Carrier] also provides coverage for the mother and newly born child for:

a. a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b. a minimum of 96 hours of in-patient Hospital care following a cesarean section.

[Carrier] provides such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or
b. the mother must request the in-patient care.

[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co-Payment per Calendar Year.

Testing Charges

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement, but the confinement must:

a. start within 14 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a Registered Nurse);

b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
   - ordered by the Covered Person's Practitioner;
   - included in the home health care plan; and
   - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

   c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
   d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   e. [Carrier] does not pay for:
   - services furnished to family members, other than the patient; or
   - services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospital Care Charges

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospital Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy

The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] **EMPLOYEE COVERAGE** [and **DEPENDENT COVERAGE**] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinary prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

[This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child.] And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based, self-funded or other health benefit arrangement, prior to enrollment under the Policy. When

this happens, if the previous plan provided coverage for a condition [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing whether or not the previous plan paid benefits for the condition to the Covered Person. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under the Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] only covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*— the treatment of malignant disease by chemical or biological antineoplastic agents.
b. *Radiation Therapy*— the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the Therapy Services listed below but only when provided on an Inpatient basis.

c. *Chelation Therapy*— means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
d. *Respiration Therapy*— the introduction of dry or moist gases into the lungs.
e. *Cognitive Rehabilitation Therapy*— the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
f. *Speech Therapy*— treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

g. *Occupational Therapy*— treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
h. *Physical Therapy*— the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*— the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Fertility Services

Subject to [Carrier] Pre-Approval [Carrier] covers charges for inpatient procedures to enhance fertility. Charges in connection with Fertility Services which are not Pre-Approved by [Carrier], or which are specifically excluded are Non-Covered Charges.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, $300 per Covered Family.

Transplant Benefits

[Carrier] covers charges for:

a. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
b. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or
b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate] You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 A.M. to 9 P.M. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered

Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%] if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%] if:

a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the Proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery by 50%] if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done; or
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost ef-

fective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of *acupuncture* except when used as a substitute for other forms of anesthesia.

Care or treatment of *alcohol abuse.*

Services for *ambulance* for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a *Christian Science* Practitioner.

Completion of claim forms.

Services or supplies related to *cosmetic surgery,* except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to *custodial* or *domiciliary* care.

Dental care or treatment, including appliances;

Charges made by a *dialysis center* for dialysis services.

Care or treatment by means of *dose-intensive chemotherapy*[, except as otherwise stated in the Policy.]

Durable Medical Equipment

Services or supplies, the primary purpose of which is *educational* providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an *emergency room* unless the Covered Person is admitted within 24 hours.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices [except as otherwise stated in the Policy.]

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) *eyeglasses* or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's *family:* spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance *fertility* which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: (a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); and (b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related to *Hearing aids and hearing exams* to determine the need for hearing aids or the need to adjust them.

Services or supplies related to *Herbal medicine.*

Care or treatment by means of *high dose chemotherapy.*

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit a felony.

Illness or *Injury,* including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for *Mental and Nervous Conditions and Substance Abuse.*

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to *Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.*

Supplies related to *Methadone* maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of the Policy.

Any charge identified as a *Non-Covered Charge* or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate except as otherwise stated in the Policy.

Non-prescription drugs or supplies, except:

a. insulin needles and syringes and glucose test strips and lancets; and

b. colostomy bags, belts, and irrigators.

Services provided by a licensed *pastoral counselor* in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care

Practitioner visits, except as otherwise stated in the Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible *Provider.*

Services related to *Private-Duty Nursing Care,* except as provided under the Home Health Care section of this [certificate].

Prosthetic Devices

The amount of any charge which is greater than a *Reasonable and Customary Charge.*

Services or supplies related to *rest or convalescent cures.*

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, *Routine examinations* or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to *Routine Foot Care.*

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a *social worker,* except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.
e. provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
   - [Subject to Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants [except as otherwise stated in the Policy.]

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a war, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] COBRA CONTINUATION RIGHTS (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the **COBRA CONTINUATION RIGHTS** section in which case;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to

continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group benefits due to any of the reasons stated above; or
b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date the Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-existing Condition of the Covered Person;

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan.
c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- Your Employer must allow for a leave of absence under Federal law in which case;
- the section applies to You.

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;
b. the end of a total leave period of 12 weeks in any 12 month period;
c. the date on which Your coverage would have ended had You not been on leave; or
d. the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or
b. the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or
b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:
- an HMO ends its operations
- Employee moves outside the HMO service area

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of an interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

Important Notice

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the Coordination of Benefits section for a definition of "allowable expense".
[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When the Policy is Primary** section below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a Federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT W

[Carrier] PLANS B, C, D, E

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICY HOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	[01-0196]
CALENDAR YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$250
PER COVERED FAMILY:	$500
COINSURANCE	20%
COINSURANCE CAPS	
PER COVERED PERSON:	$2,000
PER COVERED FAMILY:	$4,000]

[Secretary President]

[Dividends are apportioned each year.]

CERTIFICATE INDEX

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SCHEDULE OF INSURANCE [PLAN B]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment	
—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

Co-Insurance Caps

Per Covered Person per each Calendar Year	$3,000
[Per Covered Family per each Calendar Year	$6,000 [Note: Must be individually satisfied by 2 separate Covered Persons]]

Note: The Co-Insurance Caps cannot be met with:

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE [PLAN C]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

Co-Insurance Caps	
Per Covered Person per each Calendar Year	$2,500
[Per Covered Family per each Calendar Year	$5,000 [Note: Must be individually satisfied by 2 separate Covered Persons]]

Note: The Co-Insurance Caps cannot be met with:

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE [PLAN D]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%
Co-Insurance Caps	
Per Covered Person per each Calendar Year	$2,000
Per Covered Family per each Calendar Year	$4,000, [Note: Must be individually satisfied by 2 separate Covered Persons]

Note: The Co-Insurance Caps cannot be met with:

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE [PLAN E]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
Per Covered Person	$150
Per Covered Family	$300[, Note: Must be individually satisfied by 2 separate Covered Persons]

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash

Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	10%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%
Co-Insurance Caps	
Per Covered Person per each Calendar Year	$1,500
[Per Covered Family per each Calendar Year	$3,000[, Note: Must be individually satisfied by 2 separate Covered Persons]]

Note: The Co-Insurance Caps cannot be met with:

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE **EXAMPLE PPO (without Co-Payment)**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible	
Per Covered Person	[$250, $500, or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

SCHEDULE OF INSURANCE **EXAMPLE PPO (with Co-Payment)**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year
Calendar Year Cash Deductible —If treatment, services or supplies are given by an Out-Network Provider	
Per Covered Person	[$250, $500, or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year
Calendar Year Cash Deductible —If treatment, services or supplies are given by a Non-referred Provider	
Per Covered Person	[$250, $500, or $1,000]
[Per Covered Family	[$500, $1,000 or $2,000] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, except as stated below
• if treatment, services or supplies are given or referred by a non-referred Provider	20% except as stated below

Exception: for Mental and Nervous and Substance Abuse charges

• if treatment, services or supplies are given or referred by the PCP	0%
• if treatment, services or supplies are given by a non-referred Provider	25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, except as stated below.

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

[PLAN B]

Daily Room and Board Limits

• **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

• **During a Confinement in An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer]
- Fertility Services

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment	
—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar**

Year before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

[PLANS C, D, E]

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

- **During a Confinement in An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person

Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PPO/POS using PLAN B

Daily Room and Board Limits

- During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

- During a Confinement in An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

PPO/POS using PLANS C, D, E

Daily Room and Board Limits

- During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

- During a Confinement in An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these defini-

tions carefully. [Throughout this [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note:** The Emergency Room Co-Payment, if applicable, must be paid in addition to the Cash Deductible, any other Co-Payments, and Co-Insurance.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee [or a Dependent] who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

[**Dependent** means Your:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.]

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. insured for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:

a. Your legally adopted children,
b. Your step-children if such step children depend on You for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[**Dependent's Eligibility Date** means the later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.]

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee [or Dependent.]

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative resources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

[**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

Late Enrollee means an eligible Employee [or Dependent] who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** [and Dependent Coverage] section[s] of the Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs; and
f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems.

reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or
b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate], You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives, like home health care or other outpatient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person's group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] re-

Services for *ambulance* for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a *Christian Science* Practitioner.

Completion of claim forms.

Services or supplies related to *cosmetic surgery*, except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to *custodial* or *domiciliary* care.

Dental care or treatment, including appliances, except as otherwise stated in the Policy.

Care or treatment by means of *dose intensive chemotherapy,* except as otherwise stated in the Policy.

Services or supplies, the primary purpose of which is *educational* providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices except as otherwise stated in the Policy.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in the Policy, exams to determine the need for (or changes of) *eyeglasses* or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's *family:* spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance *fertility* which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); and b) drugs and drug therapy; non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Services or supplies related to *Hearing aids and hearing exams* to determine the need for hearing aids or the need to adjust them.

Services or supplies related to *Herbal medicine.*

Care or treatment by means of *high dose chemotherapy,* except as otherwise stated in the Policy.

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit a felony.

Illness or *Injury,* including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to *Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services* except as otherwise stated in the Policy.

Supplies related to *Methadone* maintenance.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of the Policy.

Any charge identified as a *Non-Covered Charge* or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate except as otherwise stated in the Policy.

Non-prescription drugs or supplies, except

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Services provided by a licensed *pastoral counselor* in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible *Provider.*

Services related to *Private-Duty Nursing care,* except as provided under the Home Health Care section of this [certificate].

The amount of any charge which is greater than a *Reasonable and Customary Charge.*

Services or supplies related to *rest or convalescent cures.*

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, *Routine examinations* or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to *Routine Foot Care*, except:

a. an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b. the removal of nail roots; and
c. treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a *social worker,* except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.
e. provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; and
   - [Subject to Carrier] Pre-Approval, full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a *war*, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the **COBRA CONTINUATION RIGHTS** section in which case;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date the Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying;

b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- Your Employer must allow for a leave of absence under Federal law in which case;
- the section applies to You.

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;

b. the end of a total leave period of 12 weeks in any 12 month period;

c. the date on which Your coverage would have ended had You not been on leave; or

d. the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or
b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law; or
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and

at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] applies only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or SAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this **Medicare as Secondary Payor** section applies to You.

If Your Employer is NOT subject to such rules, this **Medicare as Secondary Payor** section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination**

of Benefits section for a definition of "allowable expense".

[d. "We" means Carrier.]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section, below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT X

PART 1

EXPLANATION OF BRACKETS—CERTIFICATE FORMS

(PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in five ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].
2. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
3. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
4. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Some areas of variability are determined by the election made by a Carrier, or by the delivery system.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the certificate forms.

1. The face page text may be modified to be consistent with a Carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue no-name certificates.
2. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group policy.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The **BENEFIT PROVISION** of the **HEALTH BENEFITS INSURANCE** provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **NOTE: ALL plans issued by a Carrier MUST include the same option.**
4. Variable amounts appearing in the Schedule of Insurance may be included on the Schedule, or specified on the face page, sticker, or separate schedule, as discussed above.
5. The Payment of Premiums-Grace Period section of the General Provisions may be omitted from the certificate, at the option of the Carrier.
6. Dividend text which appears both on the Face Page and in the General Provisions should only be included by Carriers that could pay dividends. At the option of the carrier, such text may be omitted from the certificate.
7. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
8. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
9. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
10. The Definition of "You, Your and Yours" may be omitted. If omitted, references throughout the text to You, Your and Yours should be replaced with Employee terminology.
11. The Waiting Period provision of the Employee Coverage provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
12. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
13. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
14. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE: A Carrier may make separate elections regarding the optional benefit for Plan A and Plans B-E to either include as part of the standard plans or offer as a rider.**
15. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.
16. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.
17. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

(RIDERS)

All text which is enclosed in brackets [ ] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The Appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
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).

EXHIBIT X

PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Evidence of Coverage forms.

1. The face page text may be modified to be consistent with a Carrier's methods of Evidence of Coverage personalization. The data reflected on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the document. Carriers may also elect to use a no-name Evidence of Coverage.
2. The term "Evidence of Coverage" may be replaced with another similar term to adapt to a carrier's typical practice of providing employees with proof of coverage documents.
3. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
4. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.
5. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE: ALL plans issued by a Carrier must make the optional benefit available in the same manner.**
6. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
7. OB/GYNs can be considered Primary Care Physicians.
8. Eligible class references can be removed.
9. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
10. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
11. Small Claims Waiver can be deleted.
12. Transfer of Primary Care Physician can occur according to Carrier administration.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
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).

EXHIBIT Y

[Carrier] **HMO PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION EVIDENCE OF COVERAGE

[[Carrier] certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.]

[The Contract is an agreement between [Carrier] and the Contract Holder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.]

CONTRACT HOLDER:	[ABC Company]
GROUP CONTRACT NUMBER:	[G-12345]
[EMPLOYEE:	[John Doe]]
[CERTIFICATE NUMBER:	[C-123456]]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE:	[January 1, 1996]
[COVERED CLASSES:	[All Employees of the Contract Holder (and its Associated Companies) who permanently reside in the Service Area and are eligible or covered under the Group Care Health Plan.]]
SERVICE AREA:	[The State of New Jersey]
AFFILIATED COMPANIES:	[DEF Company]
COST OF THE COVERAGE:	

[The coverage in this Evidence of Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll.]

[HMO's Address:	[400 Main Street Chester, New Jersey 00000]]

This Evidence of Coverage replaces any older Evidence of Coverage issued to You for the Group Health Care Plan.

[Secretary President]

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I. SCHEDULE OF SERVICES

THE SERVICES OR SUPPLIES COVERED ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	COPAYMENTS[/COINSURANCE]:
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
DOCTOR SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT	None
OUTPATIENT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)
OUTPATIENT SURGERY	$15 Copayment/visit.
HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE SERVICES	Unlimited days, if preapproved.
MATERNITY (PRE-NATAL CARE)	$25 Copayment for initial visit only.
MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:	
	OUTPATIENT $15 Copayment/visit maximum 20 visits/Calendar Year.
	INPATIENT $150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year.
	Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.
THERAPEUTIC MANIPULATION	$15 Copayment/visit; maximum 30 visits/Calendar Year.
PODIATRIC	$15 Copayment/visit; (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CENTER	Unlimited days, if preapproved.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES (OUTPATIENT)	$15 Copayment/visit.

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS EVIDENCE OF COVERAGE CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

II. DEFINITIONS

The words shown below have specific meanings when used in this Evidence of Coverage. Please read these definitions carefully. Throughout the Evidence of Coverage, these defined terms appear with their initial letters capitalized. They will help Members understand what services are provided under the Group Health Care Plan.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

[**COINSURANCE.** The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

CONTRACT. The contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier] which defines the terms and conditions under which the [Carrier] agrees [to provide or arrange] health care for the Employer's Employees [or members].

CONTRACT HOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies. **Note:** The Emergency Room Co-Payment, if applicable, must be paid in addition to any other Co-Payments.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Evidence of Coverage.

Read the entire Evidence of Coverage to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help a Member meet his or her routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

[DEPENDENT.

Your:

a. legal spouse;

b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

Dependent is not a person who is covered by the Group Health Care Plan as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.]

[DEPENDENT'S ELIGIBILITY DATE.

The later of:

a. Your Employee Eligibility Date; or

b. the date the person first becomes a Dependent.]

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION. Our sole right to make a decision or determination.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily and customarily for a medical purpose;

(c) is generally not useful to a Member in the absence of an Illness or Injury; and

(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Group Health Care Plan for a Member.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Group Health Care Plan. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Group Health Care Plan's conditions of eligibility.

EMPLOYEE ELIGIBILITY DATE.

a. the date of employment; or
b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL OR INVESTIGATIONAL.

Services or supplies which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   I. The American Medical Association Drug Evaluations;
   II. The American Hospital Formulary Service Drug Information; or
   III. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

GROUP HEALTH CARE PLAN. The plan of health care coverage described in this Evidence of Coverage which a Contract Holder is providing for its Employees [or members].

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be approved for its stated purpose by Medicare; or

(b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited as a hospital by the Joint Commission; or

(b) be approved as a hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member. A Mental and Nervous Condition is not an Illness.

[**INITIAL DEPENDENT.** Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.]

INJURY. Damage to a Member's body due to accident, and all complications arising from that damage.

INPATIENT. Member if physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under the Group Health Care Plan more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** subsections of the Eligibility section appearing on later pages.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include, but are not limited to, heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;

(c) in accordance with generally accepted medical practice;

(d) not for a Member's convenience;

(e) the most appropriate level of medical care that a Member needs; and

(f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Contract (includes Subscriber covered Employee [and covered Dependents, if any)].

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.]

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-covered Services and Supplies, or which exceed any of the limitations shown in this Evidence of Coverage.

NON-[NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Group Health Care Plan.

OUTPATIENT. Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PRACTITIONER. A medical practitioner who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
(b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Group Health Care Plan.

[PRE-EXISTING CONDITION. An Illness or Injury or Mental or Nervous Condition which manifests itself in the six months before a Member's coverage under the Group Health Care Plan starts, and for which:

(a) a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

See the Non-Covered Services and Supplies section for details on how the Group Health Care Plan limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre- and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under the Group Health Care Plan. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician in conformance with Our policies and procedures that directs a Member to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) be approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre- and post-natal care, birth and treatment of the diseases and hygiene of females)].

SUBSCRIBER. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;

(b) the correction of fractures and dislocations; or

(c) pre-operative and post-operative care.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—The treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment, resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Evidence of Coverage, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

[**WE, US, OUR.** [Carrier].

YOU, YOUR AND YOURS. The Employee.]

III. ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Group Health Care Plan, all of the Contract Holder's Employees (who are in an eligible class) [and who reside in the Service Area] will be eligible if the Employees are Actively at Work Full-time Employees.

We will treat partners, proprietors and independent contractors like Employees if they meet the Group Health Care Plan's **Conditions of Eligibility**.

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not cover You unless You are an Actively at Work Full-Time Employee.

Enrollment Requirement

We will not cover You until You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee Eligibility Date, coverage will start on the Your Employee Eligibility Date.

If You enroll and agree to make the required payments, if any:

a. more than [30] days after the Your Employee Eligibility Date; or
b. after You previously had coverage which ended because You failed to make a required payment,

We will consider You to be a Late Enrollee. Late Enrollees are subject to this Group Health Plan's Pre-Existing Conditions limitation.

However, if You initially waived coverage under the Group Health Care Plan, and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under this Group Health Care Plan, We will not consider You to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, You must enroll under this Group Health Care Plan within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date You become eligible.

[The Waiting Period

The Group Health Care Plan has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Group Health Care Plan from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

The Employer who purchased the Contract may have purchased it to replace a plan the Employer had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. the Contract starts right after the old plan ends.

Multiple Employment

If You work for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Group Health Care Plan.

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments if any, within [30] days of the Employee Eligibility Date. If You do this within [30] days of the Employee Eligibility Date, Your coverage is scheduled to start on Your Employee Eligibility Date. Your Employee Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your coverage under the Group Health Care Plan will end on the first of the following dates:

a. You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. You stop being an eligible Employee under Group Health Care Plan.
c. The date this Group Health Care Plan ends, [or is discontinued for a class of Employees to which You belong.]
d. For which required payments are not made for You.
[e. You move Your permanent residence outside the Service Area.]

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This Evidence of Coverage's continuation provisions explain these situations. Read these provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

[Except as stated below, your] eligible Dependents are:

a. Your legal spouse;
b. Your unmarried Dependent children who are under age 19; and
c. Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, Your step-children if they depend on You for most of their support and maintenance and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by the Group Health Care Plan as an Employee or
b. on active duty in the armed forces of any country.

Incapacitated Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Group Health Care Plan, such a child may stay eligible for Dependent health benefits past this Group Health Care Plan's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Group Health Care Plan's age limit; and
b. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is handicapped and depends on You for most support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when Yours does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Group Health Care Plan. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent more than [30] days after the Dependent's Eligibility Date;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible Dependents who You have not elected to enroll; or
c. in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Group Health Care Plan's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Group Health Care Plan and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in this Group Health Care Plan, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, Your spouse or eligible Dependent children must be enrolled by You within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Group Health Care Plan, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and
b. Your spouse or eligible Dependent children are enrolled by You within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the exception stated below and to all of the terms of the Group Health Care Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or
b. The date You become covered for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee, the coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or
b. the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a. the date You notify [Carrier], or
b. the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date Your Dependent health coverage would otherwise start, [Carrier] will postpone the Effective Date of such coverage until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

Newborn Children

We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]
b. If You are not covered for Dependent child coverage on the date the child is born, You must:
   - make written request to enroll the newborn child.

If the request is not made within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's coverage under the Group Health Care Plan will end on the first of the following dates:

a. Your coverage ends;
b. the date the Group Health Care Plan ends;
c. the date Dependent coverage is dropped from the Group Health Care Plan for all Employees eligible for such coverage;
d. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.
e. At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.
[f. the date the Dependent moves his or her permanent residence outside the Service Area.]

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If this Contract ends and a member is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the Member.

We will only extend benefits for a Member due to the disabling condition. The charges must be incurred before the extension ends. And what We pay is based on all the terms of this Contract.

We do not pay for charges due to other conditions. And, We do not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends;
b. one year from the date the person's coverage under the Contract ends; or
c. the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under the Group Health Care Plan:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.

(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use any identification card We issue to the Member.

(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Group Health Care Plan. This condition is subject to the provisions of the section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Group Health Care Plan.

(5) **Misconduct:** The Member abuses the system, including, but not limited to: theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.

(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits and Services Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under the Group Health Care Plan immediately if termination is occurring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and

(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

IV. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by a Member's Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations **to determine the need for vision correction;**
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
4. Diagnostic Services.
5. Casts and dressings.
6. Ambulance Service when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
7. Procedures and drugs to enhance fertility, except where specifically excluded in this Evidence of Coverage.
8. Prosthetic Devices when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9. Durable Medical Equipment when ordered by a Member's Primary Care Physician and arranged through Us.
10. Prescription Drugs and contraceptives which require a Practitioner's prescription and insulin syringes and insulin needles when obtained through a Participating Provider.
11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Member's Primary Care Physician and approved in advance by Us.
12. Dental x-rays when related to Covered Services.
13. Oral surgery in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

(b) **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our preapproval:

1. Semi-private room and board accommodations

   As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

   a. a minimum of 48 hours of in-patient care in a Participating Hospital following a vaginal delivery; and

b. a minimum of 96 hours of in-patient care in a Participating Hospital following a cesarean section.

We provide such coverage subject to the following:

a. the attending Practitioner must determine that in-patient care is medically necessary; or

b. the mother must request the in-patient care.

2. Private accommodations [will be provided only when approved in advance by Us]. If a Member occupies a private room without such certification Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skill Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or the Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
22. Allogeneic bone marrow transplants

[23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health Center] upon prior written referral by a Member's Primary Care Physician.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

Chemical Dependency Admissions. Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

(e) **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
   a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a Covered Service or Supply under the Group Health Care Plan and is not a service or supply which is normally treated on a non-emergency basis; and
   c. We and a Member's Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event Members are hospitalized in a Non-participating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Non-participating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided upon prior written referral to a Participating Provider.

4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Members shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy Treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

(g) **HOME HEALTH SERVICES.** The following Services are covered when rendered by a Participating Provider including, but not limited to, a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician, Services may include home and hospital visits by nurses and social

workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

V. NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE *NOT* COVERED SERVICES UNDER THE GROUP HEALTH CARE PLAN.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Evidence of Coverage, unless it is required as a result of an Illness or Injury sustained while covered under the Group Health Care Plan or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Evidence of Coverage.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices except as otherwise stated in this Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of Your **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: (a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); and (b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, Services or supplies related to **Hearing aids** and hearing examinations to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in Evidence of Coverage.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Evidence of Coverage, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except

a. insulin needles and syringes and glucose test strips and lancets; and
b. colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until Members have been covered by this Group Health Care Plan for six months. See the "Definitions" section of this Evidence of Coverage for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child.

A new Member may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, Medicare or Medicaid or any other Federally funded health benefits program, and with respect to a group plan, an employer-based, self-funded or other health benefit arrangement, prior to enrollment under this Contract. When this happens, if the previous plan provided coverage for a condition. We give credit for the time he or she was covered under the previous plan to determine if the condition is Pre-Existing whether or not the previous plan paid benefits for the condition to the Member. We go back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Contract starts is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, and Employee must still meet it before becoming covered.

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Evidence of Coverage.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care**, except:

a. an open cutting operation to treat weak, strained, flat, unstable or unbalanced fee, metatarsalgia or bunions;
b. the removal of nail roots; and
c. treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Member would not have been charged if he or she did not have health care coverage;
d. provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Evidence of Coverage.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

VI. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Group Health Care Plan as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance coverages; nor
e. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a Subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a Subscriber or Dependent under either this Group Health Care Plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a Subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a Subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first or provides services, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a. A plan that covers a person as a Subscriber pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a Subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a Subscriber whose birthday falls later in the Calendar Year pays second. The Subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a Subscriber.
- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Group Health Care Plan when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a. this Group Health Care Plan;
b. PIP; or
c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Group Health Care Plan without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New

Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

This Group Health Care Plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Group Health Care Plan. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Group Health Care Plan may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selections regarding primacy of health coverage.

This Group Health Care Plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contract Holder's plan. In that case this Group Health Care Plan will be primary.

If there is a dispute as to which policy is primary, this Group Health Care Plan will pay benefits or provide services as if it were primary.

Services this Group Health Care Plan will provide if it is primary to PIP or OSAIC.

If this Group Health Care Plan is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Group Health Care Plan will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Group Health Care Plan will pay if it is secondary to PIP or OSAIC.

If this Group Health Care Plan is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the equivalent value of services if this Group Health Care Plan had been primary.

VIII. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Group Health Care Plan is valid unless We consent thereto.

CONFIDENTIALITY

Information contained in the medical record of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Group Health Care Plan or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Group Health Care Plan.

[CONVERSION PRIVILEGE

If a Subscriber's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.]

GOVERNING LAW

This entire Group Health Care Plan is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Group Health Care Plan is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Group Health Care Plan, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Group Health Care Plan, the holder of the card must be a Member on whose behalf all applicable premium charges under this Group Health Care Plan have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Group Health Care Plan shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Group Health Care Plan shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including, but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Group Health Care Plan, or similar causes, the rendition of medical or hospital benefits or other services provided under this Group Health Care Plan is delayed or rendered impractical. We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Group Health Care Plan shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If the Contract replaces the contract of another insurer or carrier, We may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from the Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.

2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Group Health Care Plan.

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION OF SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Group Health Care Plan only when Medically Necessary and Appropriate. We may determine whether any service or supply provided [or arranged] under the Group Health Care Plan was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Group Health Care Plan that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Group Health Care Plan.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide services and supplies to the extent stated in the Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Group Health Care Plan.

We reserve the right to modify or replace an erroneously issued Evidence of Coverage.

Information in a Member's application may not be used by Us to void the Contract or in any legal action unless the application or a duplicate of it is attached to the Contract or has been mailed to a Member.

CONTRACT INTERPRETATION

We shall administer Group Health Care Plan in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including, but not limited to, Specialist services) if a Member has not been referred by his or her Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under the Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Group Health Care Plan subject to all applicable confidentiality requirements as defined in this Evidence of Coverage. By accepting coverage under this Group Health Care Plan, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of a Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The Member can select another Primary Care Physician from Our [Physician or Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he or she attains the Group Health Care Plan's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when Your coverage ends.

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when a Member needs treatment for one of these conditions.]

IX. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Group Health Care Plan's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Group Health Care Plan at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Member is eligible to continue his or her group health benefits under both this Group Health Care Plan's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Group Health Care Plan:

If a Member elects to continue his or her group health benefits under both this Group Health Care Plan's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to the Employer's plan. You must contact Your Employer to find out if:

a. the Employer is subject to the **COBRA CONTINUATION RIGHTS** section, and therefore;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Group Health Care Plan as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Group Health Care Plan during a continuation provided by this section is not a qualified continuee.

If Your Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and

b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from You by the Employer during this extra 11 month continuation period.

If You Die While Covered

If You die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If Your Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Group Health Care Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends**.

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or

b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of You from Your spouse; or

b. the loss of dependent eligibility, as defined in this Group Health Care Plan, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his or her right to continue the Group Health Care Plan's group health benefits;

b. the monthly premium he or she must pay to continue such benefits; and

c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent's eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Contract ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other Group Health Care Plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Evidence of Coverage's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If Your Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What You Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

The subsequent premiums must be paid to the Employer, by You, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under this Group Health Care Plan on a regular basis. Any modifications made under this Group Health Care Plan will apply to similarly situated continuees. We do not ask for evidence of good health in order for You to continue.

When Continuation Ends

A Member's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Member becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Group Health Care Plan.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You are Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been covered by this Group Health Care Plan for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under this Group Health Care Plan would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under this Group Health Care Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.
b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Group Health Care Plan ends or is amended to end for the class of Employees to which You belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Group Health Care Plan.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence under Federal law and, therefore

- the section applies to You.

If Your Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a. the date You return to Full-Time work,
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which Your coverage would have ended had You not been on leave.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were covered under this Group Health Care Plan may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or
b. the date the Dependent is no longer eligible under the terms of this Group Health Care Plan.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES IF YOUR MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Group Health Care Plan on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been covered under this Group Health Care Plan for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be excessively covered; or
- [• if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if excessive coverage exists using Our standards for excessive coverage.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Group Health Care Plan ends.

After group health coverage under this Group Health Care Plan ends, the former spouse and any children covered under the individual contract may still receive benefits under this Group Health Care Plan. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Group Health Care Plan.]

X. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us under this Group Health Care Plan prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Group Health Care Plan or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

XII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

(1) In the case of an Employee, the Employee is not retired.
(2) In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.
(3) The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE

For a Member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

(1) The Member, if eligible, has enrolled in Parts A and B of Medicare.
(2) The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT Z

PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD/MAIL)**

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution-Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs for the management of nicotine dependence.
k. Charges for topical dental Fluorides.
l. Charges for any drug used in connection with baldness.
m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

EXHIBIT Z

PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution-Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigational use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs for the management of nicotine dependence.
k. Charges for topical dental Fluorides.
l. Charges for any drug used in connection with baldness.
m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

EXHIBIT Z

PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE **(MAIL)**

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury 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:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution-Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, 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 or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigational use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs for the management of nicotine dependence.
k. Charges for topical dental Fluorides.
l. Charges for any drug used in connection with baldness.
m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

EXHIBIT Z

PART 4

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and precertifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment **must** be reviewed by [XYZ] **before** it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non-emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.00] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a. 30 days of Inpatient care per Calendar Year; and

b. 20 Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;

b. the Covered Person's treatment does not comply with the treatment plan;

c. the Covered Person goes to a Provider whose services were not referred by [XYZ]; or

d. [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).

EXHIBIT AA

PART 1

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(CARD/MAIL)**

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information; or

3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution-Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail-Order Program is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs for the management of nicotine dependence.
m. Topical dental Fluorides.
n. Drugs used in connection with baldness.
o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
q. Drugs dispensed to a Member while on active duty in any armed force.
r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT AA

PART 2

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD)

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin, insulin needles and insulin syringes; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);

b. dispensed by a Participating Pharmacy; and

c. needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs for the management of nicotine dependence.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT AA

PART 3

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Mail Order Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   • a Hospital
   • a rest home
   • a sanitarium
   • a Skilled Nursing Center
   • a Substance Abuse Center
   • an alcohol abuse or mental health center
   • a convalescent home
   • a nursing home

   or similar institution.
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs for the management of nicotine dependence.
m. Topical dental Fluorides.
n. Drugs used in connection with baldness.
o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
q. Drugs dispensed to a Member while on active duty in any armed force.
r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or

conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
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).

EXHIBIT BB

PART 1

CERTIFICATION OF COMPLIANCE WITH SMALL EMPLOYER HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:21–4.2, submit this form, by March 1 of every year, in triplicate to the SEH Board at the address specified at N.J.A.C. 11:21–1.3 and one copy to the New Jersey Department of Banking and Insurance as follows: Attn: SEH Form Certification of Compliance, Office of Life and Health Actuaries, N.J. Department of Banking and Insurance, 20 West State Street, CN 325, Trenton, NJ 08625–0325. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
   Carrier Name: _____ NAIC # _____
   If an HMO, is the Carrier Federally qualified?
   ____ Yes ____ No
   Respondent's Name: _____
   Respondent's Title: _____
   Respondent's Address: _____
   _____
   Respondent's Telephone: _____ FAX: _____
2. COMPLIANCE
   Check the appropriate response(s).
   ____(a) Plans A, B, C, D and E comply fully with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.
   ____(b) Plans A, B, C, D and E comply with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21, BUT an alternative method of utilization review, as permitted at N.J.A.C. 11:21–4, is being submitted for review and approval or has already been approved by the SEH Board.
   ____(c) HMO Plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of brackets set forth at Exhibit G and K, respectively, of the Appendix to N.J.A.C. 11:21.
   ____(d) The HMO/POS plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibits HH and JJ of the Appendix to N.J.A.C. 11:21, and the HMO is in compliance with Department of Health and Senior Services regulations governing an HMO's ability to offer out-of-network services set forth at N.J.A.C. 8:38–14.
   ____(e) All standard riders applicable to Plans A through E comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth in Exhibits H, and I and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.
   ____(f) All standard riders applicable to HMO Plan and HMO/POS Plan comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth at Exhibit J and K, respectively, of the Appendix to N.J.A.C. 11:21.
   ____(g) All applications, certifications, enrollment forms, waiver forms, certificates or evidence of coverage comply with the SEH Board's forms set forth in Exhibits N, O, Q, R, S, T, V, W, Y, Z,AA, and II and the explanation of Brackets set forth at Exhibit X and JJ in the Appendix to N.J.A.C. 11:21.
3. PLAN OPTIONS AND VARIABLES
   Complete each relevant section (please use "NA" to indicate when a section is not relevant). Attach additional pages as necessary.
   (a) Plans A through E (To be completed by non-HMO carriers)
      (1) Identify the standard plans offered as a traditional contract:
      Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___
      (2) Identify the standard plans offered in conjunction with a selective contracting arrangement* (defined at N.J.A.C. 11:4–37):
      PPO Plans:
      Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___
      Indemnity POS Plans:
      Plan C:___ Plan D:___ Plan E:___
      * A carrier must first have received approval of its selective contracting arrangement by the Departments of Health and Insurance before it may issue standard small employer plans through such an arrangement. Note: Some carriers may not be subject to the statute and regulations relating to selective contracting arrangements. Such carriers should note the plans that they are offering as if they were subject to selective contracting regulations.
      (3) For all plans offered in conjunction with a selective contracting arrangement, specify the in network and out-of-network benefit levels in the space provided next to the plan (e.g., Plan D: 100%/80%), indicate whether the plan requires election of a primary care physician, and indicate the copay options available.
      PPO Plans:
      Plan A:___ Plan B:___ Plan C:___ Plan D:___ Plan E:___
      Copay:___ Copay:___ Copay:___ Copay:___ Copay:___
      Indemnity POS Plans:
      Plan C:___ Plan D:___ Plan E:___
      PCP:___ PCP:___ PCP:___
      Copay:___ Copay:___ Copay:___

(4) Do contracts provide for direct payment to health care practitioners without assignment? (Note: this option is available only on health service corporation contracts and other plans offered in conjunction with selective contracting arrangements.)
____ Yes ____ No

(5) Indicate whether any standard riders are offered, if any, and specify the plans with which they will be offered.
Prescription Drug–Card/Mail: _____
Offered with Plans: _____
Prescription Drug–Card: _____
Offered with Plans: _____
Prescription Drug–Mail: _____
Offered with Plans: _____
Mental and Nervous Conditions/Substance Abuse: _____
Offered with Plans: _____

(6) If offering the Mental/Nervous and Substance Abuse rider, indicate the applicable copayments.
_____
_____
_____
_____

(7) Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
____ Yes ____ No
If No, has the Board approved the carrier's use of an alternate participation requirements?
____ Yes ____ No
Do the plans include a dependent participation requirement?
____ Yes ____ No

(8) Do the plans include any of the following as set forth by the SEH Board?
i. Utilization Review Features
____ Yes ____ No
If No to the Utilization Review Feature, is an alternate method of utilization review included in the Plans?
____ Yes ____ No
If Yes, is it included with this submission?
____ Yes ____ No
ii. Required Hospital Stay Review
____ Yes ____ No
iii. Required Pre-surgical Review
____ Yes ____ No
iv. Alternate Treatment Features
____ Yes ____ No
v. Centers of Excellence Features
____ Yes ____ No
vi. Grievance Procedures
____ Yes ____ No

(9) Specify how the Family Deductible and Family Coinsurance Caps are being offered. (See N.J.A.C. 11:21–3.1(b))
___ Individual basis; or
___ Aggregate basis

(10) Specify how coverage for autologous bone marrow transplants is offered.
(i) Plan A selection:
___ Plan benefit; or
___ Rider benefit
(ii) Plan B through E selection:
___ Plan benefit; or
___ Rider benefit

(b) HMO Plan (To be completed by HMO carriers)
HMO Contracts:
(1) List the copayment options being offered.
___$5 Copay ___$10 Copay ___$15 Copay ___$20 Copay
(2) How is the in-plan prescription drug coverage being offered?
___$15 Copay ___50% Coinsurance
(3) Specify the standard riders being offered, if any, and specify the plan with which they will be offered.
Prescription Drug–Card/Mail: _____
Offered with Plans: _____
Prescription Drug–Card: _____
Offered with Plans: _____
Prescription Drug–Mail: _____
Offered with Plans: _____
Mental and Nervous Conditions/Substance Abuse: _____
Offered with Plans: _____
(4) Do the participation requirements comply with applicable statutes and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
____ Yes ____ No
If No, has the Board approved the carrier's use of an alternate participation requirement?
____ Yes ____ No
(5) Indicate how coverage for autologous bone marrow transplants is offered.
___ Plan benefit; or
___ Rider benefit

HMO/POS Contracts:
(1) List the copayment options being offered.
___$5 Copay ___$10 Copay ___$15 Copay ___$20 Copay
(2) How is the in-plan prescription drug coverage being offered?
$5 Copay Non-network coinsurance level
$10 Copay Non-network coinsurance level
$15 Copay Non-network coinsurance level
$20 Copay Non-network coinsurance level
(3) Do the participation requirements comply with applicable statutes and rules? (See N.J.S.A. 17B:27A–24 and N.J.A.C. 11:21–7.6)
____ Yes ____ No
If No, has the Board approved the carrier's use of an alternate participation requirement?
____ Yes ____ No
(4) Indicate how coverage for autologous bone marrow transplants is offered.
___ Plan benefit; or
___ Rider benefit

(c) Additional Forms
(1) Is the Preexisting Condition Statement, Exhibit S, being used?
____ Yes ____ No

(d) Additional Options
(1) Is payment by automatic bank withdrawal required?
____ Yes ____ No
(2) Is payment by automatic bank withdrawal offered? (Note: If offered, must be offered on all plans to all small employers.)
____ Yes ____ No

4. CERTIFICATION

I, the Undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

I certify that any stop loss or excess risk insurance issued or renewed by the carrier meets the retention limits set forth in the definition of "stop loss" or "excess risk insurance" as defined at N.J.S.A. 17B:27A–17, as amended by P.L. 1995, c.298.

Date _____ Signature (No stamps) _____

Title _____

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT BB
PART 2
CERTIFICATION OF PROMOTIONAL AND MARKETING MATERIAL

Submit this form pursuant to N.J.A.C. 11:21–17.3 by March 1 of every year to the SEH Board at the address specified at N.J.A.C. 11:21–1.3 and to the Division of Life and Health Actuarial Services, New Jersey Department of Banking and Insurance, 20 W. State Street, CN–325, Trenton, NJ 08625–0325, Attn: SEH Promotional and Marketing Certification.

Carrier's Name: _____ NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
Respondent's Phone: _____ FAX: _____

I, the undersigned, hereby certify that the promotional and marketing material to be disseminated regarding all the standard small employer health benefits plans, including all terms definitions and text, are consistent with N.J.S.A. 17B:27A–17 et seq. and N.J.A.C. 11:21.

I certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

Date _____ Signature (No stamps) _____

Title _____

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT BB
PART 3
CERTIFICATION OF PRIOR FILING AND COMPLIANCE WITH P.L. 1994, C.11

In accordance with N.J.A.C. 11:21–11.8(a), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21–1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN–325, Trenton, NJ 08625–0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
   Carrier's Name: _____
   NAIC # : _____
   Respondent's Name: _____
   Respondent's Title: _____
   Respondent's Address: _____
   _____
   Respondent's Phone: _____ FAX: _____
2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION (Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)
   a. Form identification number: _____
   b. Form's market name: _____
   c. Date filed (approved) by the Commissioner: _____
   d. Specify which of the following have been approved with respect to this form, providing the most recent date that an approval was received for each:
      Form amendment: _____
      Rider form: _____
      Endorsement form: _____
   e. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?
      ____ Yes ____ No
      If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:
      _____
      _____
      _____
      ____ Check here if additional pages are attached.
   f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?
      ____ Yes ____ No ____ NA
   g. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by which this nonstandard health benefits plan is sold or marketed?
      ____ Yes ____ No ____ NA
      If no, does the carrier market and sell the nonstandard health benefits plan through:
      Agent force: ____ Yes ____ No
      Direct sale: ____ Yes ____ No
   h. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):

January:	_____	July:	_____
February:	_____	August:	_____
March:	_____	September:	_____
April:	_____	October:	_____
May:	_____	November:	_____
June:	_____	December:	_____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L. 1994, c. 11, and rules and promulgated thereunder, specifically N.J.A.C. 11:21-3A.

4. CERTIFICATION
I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefit plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____
Date Signature

_____
Title

New Rule, R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

EXHIBIT BB

PART 4

CERTIFICATION OF INFORMATIONAL FILING AND COMPLIANCE WITH P.L. 1994, C.11

In accordance with N.J.A.C. 11:21–11.8(b), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21–1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN–325, Trenton, NJ 08625–0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
Carrier's Name: _____
NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
_____
Respondent's Phone: _____ FAX: _____
2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION
(Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)
a. Form identification number: _____
b. Form's market name: _____
c. Specify the reason(s) why this nonstandard health benefits plan was not submitted to the Department for filing prior to April 4, 1994:
_____
_____
_____
____ Check here if additional pages are attached.
d. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No
If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:
_____
_____
_____
____ Check here if additional pages are attached.
e. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No ____ NA
If yes, specify the final date that policies, contracts or certificates will be issued under this nonstandard health benefits plan: ____
f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by which this nonstandard health benefits plan is sold and marketed?
____ Yes ____ No ____ NA
If no, does the carrier market and sell the nonstandard health benefits plan through:
Agent force: ____ Yes ____ No
Direct sale: ____ Yes ____ No
g. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):

January:	_____	July:	_____
February:	_____	August:	_____
March:	_____	September:	_____
April:	_____	October:	_____
May:	_____	November:	_____
June:	_____	December:	_____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L. 1994, c. 11, and rules promulgated thereunder.
4. CERTIFICATION
I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed

under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.

I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefits plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____

Date Signature

_____

Title

New Rule, R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

EXHIBIT CC

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

CARRIER SMALL EMPLOYER MARKET SHARE REPORT

This report must be completed in accordance with the provisions of N.J.A.C. 11:21–10, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier. Reports must be completed and returned on or before April 15, 1994 and by March 1 of each year thereafter. Completed Reports must be returned to the SEH Program Administrator as set forth at N.J.A.C. 11:21–1.3.

Part A. Carrier Information
1. Carrier's Name: _____
2. Carrier's NAIC Number: _____
3. Is the above named Carrier an affiliated Carrier?
_____ Yes _____ No
   a. If Yes, please list all Carriers with whom the above named Carrier is affiliated. List only those affiliates that had group health benefits plans in force for small employers in the preceding calendar year.

   Name NAIC #

   _____
   _____
   _____
   _____

Part B. Personal Respondent Information
1. Name: _____
2. Title: _____
3. Mailing Address: _____
_____
4. Telephone No. _____ Facsimile No. _____

Part C. Calendar Year Information for 199__
Net earned premium for all small employer group health benefits plans: $_____

Part D. Certification
I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:21-X.

_____ _____ _____

Signature Title Date

New Rule, R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

Exhibit DD

[Carrier]

AMENDMENT

[Policyholder]

Group [Policy] No.

Effective Date:

[

]

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].

[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1995 d.312, effective June 19, 1995.
See: 27 N.J.R. 439(a), 27 N.J.R. 2407(b).

EXHIBIT EE

(RESERVED)

EXHIBIT FF

SEH PROGRAM PREMIUM COMPARISON SURVEY

Submit this completed survey in duplicate no later than September 1 of each year to: SEH Program Premium Comparison Survey, Division of Public Affairs, New Jersey Department of Insurance, 20 West State Street, CN 325, Trenton, New Jersey 08625.

Part 1

COMPANY AND RESPONDENT INFORMATION

Company Name: _____ NAIC: _____

Respondent's Name: _____

Respondent's Title: _____

Respondent's Address: _____

Respondent's Telephone: _____

Respondent's Facsimile: _____

Part 2

TOLL-FREE INFORMATION

Company's Toll-Free Telephone number where an applicant may obtain a premium quote: _____

Please indicate if a switchboard or message recording is reached by the toll-free number and the respective period of service:

Switchboard Service Times: _____

Message Recording Service Times: _____

Part 3

DIRECTIONS FOR COMPLETING THE PREMIUM SURVEY

A. Specify the monthly premium, rounded to the nearest whole dollar, that will be charged for a standard policy issued on the next January 1 to an employer as set forth in paragraph C below, for each policy form and rider in the categories listed in the survey for each plan in accordance with paragraph D below. In showing the rider premium, list only the additional premium for a rider, not the total premium for a plan including the rider. The following abbreviations apply:

SCA = Selective Contracting Arrangement (that is, an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations (see N.J.A.C. 11:4-37.2)).
NR = The plan is offered or purchased without any standard riders.
PC = The prescription card rider (Exhibit H or J, Part 2 of the Appendix to N.J.A.C. 11:21).
PM = The prescription mail order rider (Exhibit H or J, Part 3 of the Appendix to N.J.A.C. 11:21).
PMC = The prescription card and mail order rider (Exhibit H or J, Part 1 of the Appendix to N.J.A.C. 11:21).
MH = The mental/nervous and substance abuse rider (Exhibit I of the Appendix to N.J.A.C. 11:21).

B. Use "NA" to indicate when any rider or plan variation is not being offered.

C. For purposes of completing the survey, assume the following policyholder:

Three small employers, one of each employer being located in the following counties: Camden, Middlesex, and Bergen, and each with six employees as follows:

1. Single Female—age 27
2. Single Male—age 37
3. Female Parent—age 47, with two children
4. Male Employee and Spouse—both age 57
5. Male Employee—age 27
   Spouse—age 24
   Two children—both under age 18
6. Female Employee—age 47
   Spouse—age 50
   Two children—both under age 18

D. For purposes of completing the survey, show the premium for only one delivery system option as described on the form, and indicate by checking the appropriate space if other delivery systems for the plan are available.

Part 4

PREMIUM SURVEY

PLAN A

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY___

PLAN A PREMIUM 1/1/19___

Camden

	NR
$250	$_____

Middlesex

$250	$_____

Bergen

$250	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional ____

SCA—No Gatekeeper ____

SCA—Gatekeeper ____

Other Delivery Systems Available: Yes ___ No ___

Note: Coinsurance percentages for Plan A are established by rule — no variations are permitted. See Exhibit A of Appendix to N.J.A.C. 11:21.

PLAN B

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—

PLAN B PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper ____

Coinsurance Percentage:

In-Network ____ Copay (if any) $____

Out-of-Network ____

SCA—Gatekeeper ____

Coinsurance Percentage:

In-Network ____ Copay (if any) $____

Out-of-Network ____

Other Delivery Systems Available: Yes ____ No ____.

PLAN C

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—PLAN C PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN D

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—PLAN D PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN E

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—

PLAN E PREMIUM 1/1/19__

Camden

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:

In-Network ____ Copay (if any) $_____

Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

HMO PLAN

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—

HMO PLAN PREMIUM 1/1/19__

Camden

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

New Rule, R.1995 d.289, effective June 5, 1995.
See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

EXHIBIT GG

Loss Ratio Report Form

New Jersey Small Employer Health Benefits Program Reporting Year ___

For Preceding Calendar Year Ending December 31, ___

Name of Carrier: _____ NAIC # _____

Address: _____

Check one: Insurance Company ___ HMO ___ Service Plan ___

A separate Report Form should be completed and filed for each affiliate. Definitions and instructions regarding words and terms appearing below may be found on the reverse side.

	Total	Standard Plans A	B	C	D	E/HMO	Non-Standard Plans
1. Premiums	_____	_____	_____	_____	_____	_____	_____
2. Claims (a. + b. - c. + d. - e.) (See definitions, reverse side)	_____	_____	_____	_____	_____	_____	_____
a.	_____	_____	_____	_____	_____	_____	_____
b.	_____	_____	_____	_____	_____	_____	_____
c.	_____	_____	_____	_____	_____	_____	_____
d.	_____	_____	_____	_____	_____	_____	_____
e.	_____	_____	_____	_____	_____	_____	_____

	Total	Standard Plans A	B	C	D	E/HMO	Non-Standard Plans
3. Loss Ratio (2. ÷ 1.)							
4. Total Employee Months Exposed							
5. Dividends (.75 × 1. - 2.)							
6. Dividend Percentage (5. ÷ 1.)							

I certify that the above information is accurate and complete and has been prepared in accordance with N.J.A.C. 11:21-7A. If Dividends (or credits) are required, an explanation of our plan to issue them is attached.

Actuary's Signature | Date | Type or Print Actuary's Name

Title | Telephone Number

REPORTING FORM DEFINITIONS AND INSTRUCTIONS

1. "Premiums" are the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before refunds or credits applicable to prior years, for each Standard Plan separately, and for Non-Standard Plans as a whole. Include all Rider Premiums, both Standard and Non-Standard Riders, with the respective Plans which are ridered. The Non-Standard Plans column is for the policies which are renewal only policies continued pursuant to N.J.S.A. 17B:27A–19j.

2. "Claims" are equal to

a. claims paid in the preceding calendar year regardless of the year incurred;

b. plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

c. less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding calendar year's Loss Ratio Report);

d. plus a residential reserve equal to 3.3 percent of a. through c. above;

e. less the residual reserve as reported in the preceding calendar year's Loss Ratio Report.

3. "Loss Ratio" is the quotient, to the nearest .1 percent, of the Claims divided by the Premiums (2. divided by 1.).

4. "Total Employee Months Exposed" is defined as the sum of the number of months that each employee was covered during the year. For example, if 40 employees were covered for 3 months, 5 employees were covered for 10 months and 12 employees were covered for 12 months, then the Total Employee Months Exposed would be 314 ({40 × 3} + {5 × 10} + {12 × 12}).

5. "Dividends" are calculated for each standard plan whose Total Employee Months Exposed is equal to 10,000 or more; on a combined basis for all standard plans whose Total Employee Months Exposed is less than 10,000; and for the non-standard plans as a whole. "Dividends" are equal to 75 percent of the Premiums less Claims (75% of 1. less 2.). (No dividends are required to be paid for non-standard plans for reporting year 1995.)

6. "Dividend Percentage" is the percentage ratio of Dividends to Premiums (5. divided by 1.).

Loss Ratio Reports are required to be completed and filed with the Department on or before August 1 of each year for the preceding calendar year. Reports should be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings
Office of the Life & Health Actuary
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, NJ 08625–0325

New Rule, R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

EXHIBIT HH

[Carrier] **HMO—POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE CONTRACT

CONTRACTHOLDER: [ABC Company]
GROUP CONTRACT NUMBER: [G-12345]
GOVERNING JURISDICTION: NEW JERSEY
EFFECTIVE DATE OF CONTRACT: [January 1, 1996]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 1997.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1996.]

AFFILIATED COMPANIES: [DEF Company]

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies and pay benefits in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Contract.

The Effective Date is specified above.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its **General Provisions.**

[Secretary President]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Covered Employee Only	$]
[Covered Employee and Spouse	$
Covered Employee and Child(ren)	$
Covered Employee and Family	$

(including Covered Employee, spouse and one or more eligible dependents)]

We have the right to change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled **General Provisions.**

This Contract's classification, and the coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]

Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated below for Prescription Drugs]

[NON-NETWORK]

Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family][Note: Must be individually satisfied by 2 separate [Members]

Medicare Alternate Deductible

For a [Member] who is eligible for Medicare by reason of disability, but is not covered by both Parts A and B, the

Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid if the [Member] had been so covered.

After the 18 month period described in Medicare as Secondary Payor ends with respect to a [Member] who is eligible for Medicare solely on the basis of end stage renal Disease, but is not covered by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the [Member] been so covered.

Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] **[except as stated below]**
Exception: For charges for Mental or Nervous Conditions and Substance Abuse treatment	[25%]
Coinsured Charge Limit	$10,000
MAXIMUM LIFETIME BENEFITS	Unlimited, except as otherwise stated

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Hospital		
Inpatient (unlimited days)	[$150] Copayment/day; maximum/admission [$750]; maximum/cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment/visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	$50 Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	$50 copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Maternity	$25 Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$15] Copayment/visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Mental or Nervous Conditions and Substance Abuse	Inpatient: [$150] Copayment/day; maximum/admission [$750]; maximum/cal. year [$1500]; Maximum 30 days/calendar year Outpatient: [$15] Copayment/visit; Maximum 20 visits/calendar year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	Deductible/Coinsurance $5,000/calendar year; $25,000/lifetime maximum benefit for Inpatient and Outpatient care, combined

SERVICES	[NETWORK]	[NON-NETWORK]
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment/visit	Deductible/Coinsurance
Prescription Drugs	at the option of the Carrier: [$15] Copayment per prescription; or the [Non-Network] Coinsurance	Deductible/Coinsurance
Home Health Care	Covered	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered	Deductible/Coinsurance; Subject to Pre-Approval
Podiatric Care	[$15] Copayment/visit	Deductible/Coinsurance

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THIS CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits Applicable to [Non-Network] Benefits

During a Period of Hospital Confinement

For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, We will cover charges up to the Hospital's average semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the [Member] is being isolated in a private room because the [Member] has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

For Special Care Units, We will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement in an Extended Care Center or Rehabilitation Center

We will cover the lesser of:

a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving

equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:

a) accredited for its stated purpose by either the Joint Commission or the Accreditation for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contractholder through common ownership of stock or assets.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:

a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before this Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of this Contract for details.

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a [Member]. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. NOTE: The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Co-Insurance.

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges and Covered Charges with Special Limitations** section of this Contract, as applicable to [Non-Network] benefits. The services and supplies must be:

a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by this Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

a) is furnished mainly to help a [Member] meet a [Member's] routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT. An Employee's:

a) legal spouse;
b) unmarried Dependent child who is under age 19; and unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of this Contract.

An Employee's "unmarried Dependent child" includes his or her legally adopted child, his or her step-child if such step-child depends on the Employee for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by this Contract as an Employee.

At Our Discretion, We can require proof that a person meets the definition of a Dependent.]

[DEPENDENT'S ELIGIBILITY DATE.

The later of:

a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION/DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We [or the Care Manager] Determine to be:

a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a [Member's] home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Contractholder, or the date coverage begins under this Contract for a [Member], as the context in which the term is used suggests.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] Determine are:

a) not of proven benefit for the particular diagnosis or treatment of a [Member's] particular condition; or

b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member's] particular condition; or

c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member's] particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a [Member's] particular condition, as explained below.

We [or the Care Manager] will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   a) The American Medical Association Drug Evaluations;
   b) The American Hospital Formulary Service Drug Information; or
   c) The United States Pharmacopeia Drug Information recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

FACILITY. A place which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Contract.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A–19). Health Benefits Plan excludes the following plans, policies or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c. 70 (C. 39: 6A–1 et seq.).

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] Practitioners provide Covered Services and Supplies to [Members].

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited as a hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a [Member]. A Mental or Nervous Condition is not an Illness.

[**INITIAL DEPENDENT.** Those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

INJURY. Damage to a [Member's] body due to accident, and all complications arising from that damage.

INPATIENT. [Member], if physically confined as a registered bed patient in a Hospital or other health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under this Contract more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage [and Dependent Coverage] subsection[s] of the Eligibility section of this Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include but are not limited to heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] Determine to be:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER.] An eligible person who is covered under this Contract (includes Covered Employee[and covered Dependents, if any)].

[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;

b) approved for its stated purpose by Medicare; or

c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental or Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-COVERED CHARGES. Charges which do not meet this Contract's definition of Covered Charges or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by this Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in this Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and

b) provides medical services which are within the scope of the nurse's license or certificate and are covered by this Contract.

OUTPATIENT. [Member], if not confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We [or the Care Manager] Determine if the cause(s) of the confinements are the same or related.

PER LIFETIME. During the lifetime of an individual, regardless of whether he or she was covered under this Contract or any other contract, policy or plan:

a) as an Employee or Dependent; and

b) with or without interruption of coverage.

PRACTITIONER. A medical practitioner who:

a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

PRE-APPROVAL or PRE-APPROVED. Our written approval for specified services and supplies prior to the date the charges are incurred. Services or supplies for which the charges have not been pre-approved are not covered.

[**PRE-EXISTING CONDITION.** An Illness or Injury which manifests itself in the six months before a [Member's] coverage under this Contract starts, and for which:

a) A [Member] sees a Practitioner, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the [Member's] coverage starts; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a [Member's] coverage starts is also a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of this Contract for details on how this Contract limits the services and benefits for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:

a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
   - The American Medical Association Drug Evaluations;
   - The American Hospital Formulary Service Drug Information;
   - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:

a) drugs labeled: "Caution-Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to [Network] services and supplies, the negotiated arrangement. With respect to [Non-Network] benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the [Non-Network] benefits under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the Care Manager] in conformance with Our policies and procedures that directs a [Member] to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hyper-

trophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The Schedule of Covered Services and Supplies and Covered Charges.

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer. State, county, or municipal bodies, agencies, boards or departments are not considered to be small employers for the purpose of this contract.

SPECIAL CARE UNIT. A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as surgery.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy-the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy-the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy-retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment-the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy-the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy-treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy-the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy-the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy-the introduction of dry or moist gases into the lungs.

Speech Therapy-treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

We will not cover an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

We will not cover the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage will start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment;

We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Contract, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a) termination of employment;
b) divorce;
c) death of the Employee's spouse; or
d) termination of the other plan's coverage.

But, the Employee must enroll under this Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:

a) the Employee was employed by the Employer on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Multiple Employment

If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Contract. But, if this Contract uses the amount of an Employee's earnings to determine class, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, We will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of an Employee's coverage.

When Employee Coverage Ends

An Employee's coverage under this Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Contract.
c) the date this Contract ends, [or is discontinued for a class of Employees to which the Employee belongs.]
d) the last day of the period for which required payments have been made for the Employee, subject to the **Payment of Premium-Grace Period** section.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Contract's benefits provisions explain these situations. Read this Contract's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are:

a) the Employee's legal spouse;
b) the Employee's unmarried Dependent children who are under age 19; and
c) the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Eligible Dependents will not include any Dependent who is:

a) covered by this Contract as an Employee or
b) on active duty in the armed forces of any country.

Adopted Children and Step-Children

An Employee's "unmarried Dependent children" include the Employee's legally adopted children, his or her step-children if they depend on the Employee for most of their support and maintenance and children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached this Contract's age limit;
b) the child became covered under this Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is handicapped and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. We consider an eligible Dependent to be a Late Enrollee, if the Employee:

a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a) termination of employment;
b) divorce;
c) death of the Employee's spouse; or
d) termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee, and the appropriate premium must be paid, within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:

a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

When Dependent Coverage Starts

In order for an Employee's Dependent coverage to begin, the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below, and to all of the terms of this Contract, the date an Employee's Dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date the Employee signs the enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, We will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility; or the day after home confinement ends.

Newborn Children

We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid] [.] [and, in order to access [Network] services and supplies, the Employee must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   1) make written request to enroll the newborn child[; and
   2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the request is not made [and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends

A Dependent's coverage under this Contract will end on the first of the following dates:

a) [the date] Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)] the date this Contract ends;
[d)] the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)] At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If this Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under this Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of this Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies, or charges incurred by other family members.

The extension ends on the earliest of:

a) the date the Total Disability ends;
b) one year from the date the person's coverage under this Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:

a) **Untenable Relationship**: After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the [Member].

c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
e) **Misconduct:** The [Member] abuses the system, including, but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

MEMBER PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician and identify himself or herself as a [Member] of this program.

In a Medical Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We [or the Care Manager] will provide services only if We Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The [Member] can select another Primary Care Physician from Our [Physician or Practitioners Directory].

[Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If We receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

IDENTIFICATION CARD

The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Except in the case of a Medical Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Physician (including, but not limited to, Specialist Services) if a [Member] has not been referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A [Member] may, for personal reasons, disagree or not comply with procedures, medicines, or courses of treatment recommended by a [Network] Practitioner or ignore treatment that is deemed Medically Necessary and Appropriate by a [Network] Practitioner. If such [Network] Physician (after a second [Network] Practitioner's opinion, if requested by [Member]), believes that no professionally acceptable alternative exists, and if after being so advised, [Member] still refuses to comply with or accept the recommended treatment or procedure, neither the Practitioner, nor We, or any [Network] Provider will have further responsibility to provide any of the [Network] services and supplies available under this Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to [Member] of a decision not to provide further [Network] services and supplies for a particular condition. The decision is subject to the Appeals Procedures. Treatment for the condition involved will be resumed in the event [Member] agrees to follow the recommended treatment or procedure. Note: While no [Network] services and supplies will be available, the [Member] may still be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract concerning [Non-Network] benefits.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

a) No [Network] Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any [Network] Provider or other Provider, institution, Facility or agency.

b) Neither the Contractholder nor any [Member] is our agent, representative or employee, or an agent or representative of any [Network] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.

c) [Network] Practitioners maintain the physician-patient relationship with [Members] and are solely responsible to [Members] for all medical services which are rendered by [Network] Practitioners.

d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

COVERED SERVICES AND SUPPLIES APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [or Coinsurance] as stated in the applicable Schedule.

Please read the COVERED SERVICES AND SUPPLIES section carefully.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a Member's Primary Care Physician.
3) **Periodic health examinations** to include:
   - Well child care from birth including immunizations;
   - Routine physical examinations, including eye examinations;
   - Routine gynecological exams and related services;
   - Routine ear and hearing examination; and
   - Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).
4) **Diagnostic Services.**
5) **Casts and dressings.**
6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Physician and approved in advance by Us.
7) **Procedures and prescription drugs to enhance fertility**, except where specifically excluded in this Contract.
8) **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.
10) **Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.
11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontegenic cysts, and other surgical procedures, as We approve.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office[, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]facilities upon prior written authorization by Us); however, [Network] Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

1. Semi-private room and board accommodations
   - As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
     - a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and
     - a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.
   - We provide such coverage subject to the following:
     - the attending Practitioner must determine that inpatient care is medically necessary; or
     - the mother must request the inpatient care.
   - [As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals

9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS.** The following Services are covered when rendered by a [Network] Provider at Provider's office or at a [Network] Substance Abuse Center [or Health Center] [upon prior Referral by a [Member's] Primary Care Physician] [or the Care Manager].

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member's] Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** [Members] are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that [Members] have been cooperative with an on-going treatment plan. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate, and only to the extent of the covered benefit as defined above.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS BENEFITS A [MEMBER] RECEIVES AS [NON-NETWORK] BENEFITS WILL REDUCE THE BENEFITS AVAILABLE AS [NETWORK] MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES.

(e) **EMERGENCY CARE BENEFITS-WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Physician in the event of a Medical Emergency as Determined by Us.

1) A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center][or Us] [or the Care Manager] prior to seeking emergency treatment.

2) We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior Referral only if:

- Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
- The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-emergency basis; and

- We and a [Member's] Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3) In the event [Members] are hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or [Members] shall be responsible for payment.

5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager].

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a [Network] Provider by a [Member's] Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a [Member's] Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a [Member's] condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy and Respiration Therapy.

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.

(g) **HOME HEALTH SERVICES.** The following services are covered when rendered by a [Network] Provider including but not limited to a [Network] Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a [Member's] Primary Care Physician **[or the Care Manager]**.

1. **Skilled nursing services**, provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide**, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a [Member's] medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member's] Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and

3) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

[NON-NETWORK] BENEFIT PROVISION APPLICABLE TO [NON-NETWORK] BENEFITS

The Cash Deductible

Each Calendar Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that [Member], less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that [Member] is covered by this Contract. And what We pay is based on all the terms of this Contract.

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:

a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the Calendar Year in which this Contract starts;
b) the charges would have been considered Covered Charges under this Contract if this Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit

This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Per Family

The Per Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more [Members] in a family have incurred a combined total of Covered Charges toward their Per Person Cash Deductible equal to the per Family Cash Deductible, each [Member] in that family will be considered to have met his or her Per Person Cash Deductible for the rest of that Calendar Year. The Charges that each [Member] in a family may use toward the Per Family Cash Deductible may not exceed the amount of the Per Person Cash Deductible.]

Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a [Member] must incur each Calendar Year before no Coinsurance is required, **except as stated below.**

Exception: Charges for Mental or Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

COVERED CHARGES APPLICABLE TO [NON-NETWORK] BENEFITS

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of this Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced or eliminated if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in this Contract.

Hospital Charges

We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement.

As an **exception** to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.

If a [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. This Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Contract.

Emergency Room Copayment Requirement

Each time a [Member] uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the [Member's] health.

Extended Care or Rehabilitation Charges

Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Home Health Care Charges:

Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;

f) speech therapy;
g) home health aide services;
h) medical appliances and equipment-drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Contract and to the following conditions:
   1) The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
      - ordered by the [Member's] Practitioner;
      - included in the home health care plan: and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
   2) The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.
   3) The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
   4) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   5) We do not pay for:
      - services furnished to family members, other than the patient; or
      - services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

Practitioner's Charges for Non-Surgical Care and Treatment

We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

Practitioner's Charges for Surgery

We cover Practitioner's charges for Medically Necessary and Appropriate Surgery. We do not pay for Cosmetic Surgery.

Second Opinion Charges

We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured [Member]. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of this Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Contract. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;

c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:

a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

Alcohol Abuse

We pay benefits for the Covered Charges a [Member] incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:

a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

This Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

Birthing Center Charges

We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of this Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Anesthetics and Other Services and Supplies

We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But We do not pay for replacements or repairs.

Blood

We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the [Member].

Ambulance Charges

We cover Medically Necessary and Appropriate charges for transporting a [Member] to:

a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:

a) any purchases without Our advance written approval;
b) replacements or repairs; or

c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor

We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Contract.

Nutritional Counseling

Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

X-Rays and Laboratory Tests

We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of this Contract.

Dental Care and Treatment

We cover:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

Mammogram Charges

We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of this Contract, and the following limitations:

We will cover charges for:

a) one baseline mammogram for a female [Member], ages 35–39
b) one mammogram, every 2 years, for a female [Member], ages 40–49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female [Member] ages 50 and older.

Private Duty Nursing Care

We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

We cover the following Therapy Services:

Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

We cover the Therapy Services listed below, subject to stated limitations:

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services

Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

Preventive Care

We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:

a) $500 per [Member] for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per [Member] for all other [Members].

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Vision Screening

We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation

We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Mental or Nervous Conditions and Substance Abuse

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A [Member] may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The [Member] must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit what We pay each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. We limit what We pay Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich
- Subject to Our Pre-Approval, breast cancer, if the Member is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which We do not Pre-Approve are not covered.**]

[h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in this Contract, unless it is required as a result of an Illness or Injury sustained while covered under this Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;

b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or

c. **eye** surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in this Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine**.

Services or supplies related to **Hypnotism**.

Services or supplies because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to Marriage, career or financial counseling, sex therapy or family therapy, and related services.

Supplies related to **Methadone** maintenance.

With respect to [Non-Network] benefits, **Nicotine Dependence** Treatment, except as otherwise stated in the Preventive Care section of this Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;

a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] coverage under this Contract starts, and for which:

a) a [Member] sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a [Member's] coverage starts is also a Pre-Existing Condition.

We do not pay benefits for charges for Pre-Existing Conditions until the [Member] has been continuously covered by this Contract for 180 days.

This limitation does not affect benefits for other unrelated conditions[, or birth defects in a covered Dependent child]. And We wave this limitation for a [Member's] Pre-Existing Condition if the condition was payable under another carrier's group plan which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage

A new [Member] may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based self-funded or other health benefit arrangement, prior to enrollment under this Contract. When this happens, if the previous plan provided coverage for a condition, We give credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing, whether or not the previous plan paid benefits for the condition to the [Member]. We go back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must

start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Contract starts is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** except as specified in this Contract.

With respect to [Non-Network] benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of this Contract.

Services or supplies that are not furnished by an eligible **Provider**.

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to [Network] services and supplies provided in the event of a Medical Emergency, and with respect to all [Non-Network] benefits.

Services or supplies related to **rest or convalescent cures**.

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of this Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except**:

a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a) eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;
e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and
   - Subject to Our Pre-Approval, full-time student status, provided the [Member] is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker**, except as otherwise stated in this Contract.

Stand-by services required by a Provider.

Sterilization reversal-services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member's] sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

[IMPORTANT NOTICE APPLICABLE ONLY TO [NON-NETWORK] BENEFITS

[This Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC-Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a [Member]:

a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under this Contract. See the **Utilization Review Features** section for details.]

[This Contract has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a [Members] medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[This Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of this Contract. Read this Contract carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Contract he or she should [call The Group Claim Office at the number shown on his or her Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with this Contract's utilization review features, he or she will not be eligible for full benefits under this Contract.

Compliance with this Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under this Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Contract.

Definitions

"Hospital admission" means admission of a [Member] to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the [Member's] condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the [Member's] life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Contract is not payable under this Contract.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a [Member] is not satisfied with a utilization review decision, the [Member] or the [Member's] Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review Practitioner. This Practitioner will discuss the case with the Practitioner reviewer who made the initial decision. The second medical review Practitioner will then discuss the case with the [Member's] Practitioner. The Member's Practitioner is then notified of the appeal's recommendation and referred to Us for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Contract.

Notice of Hospital Admission Required

We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the re-

quirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The [Member] or the [Member's] Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a [Member] or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC]notifies the [Member's] Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:

a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review

The [Member] or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The [Member], or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the [Member's] Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, **by 50%**] if:

a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

[ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or

[ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges **by 50%**], if:

a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet this Contract's:

a) Cash Deductible; or
b) Coinsured Charge Limit.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Contract.

We require a [Member] to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The [Member] or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] must obtain a second surgical opinion in order to get full benefits under this Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the [Member]. The Practitioner he or she chooses fills them out. and then returns them to [ABC].

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Contract, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the Required Pre-Hospital Review section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:

a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Contract's:

a) Cash Deductible; or
b) Coinsured Charge Limit.

[ALTERNATE TREATMENT FEATURES

Important Notice: No [Member] is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a) They are Determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a [Member] in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under this Contract.

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or Us to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the [Member], [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a) the [Member], or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Alternate Treatment Plan includes:

a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Contract.

The agreed upon alternate treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that We [or the Care Manager] determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the [Member] is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be considered as Covered Charges, the Center of Excellence must:

a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the [Member].

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Contract. However, the Utilization Review Features will not apply.]]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A [Member] may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits;
d) Supplemental Limited Benefits Insurance coverages; nor
e) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.
- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:

a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means that of service or expense provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services and Benefits this Contract will provide if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will provide services and benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:

a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments; or
b) the equivalent value of services if this Contract had been primary.

Medicare

If the [Non-Network] benefits under this Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AFFILIATED COMPANIES

If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

An Employee of the Contractholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Contract. That Employee's service with multiple Employers will be treated as service with that one.

The Contractholder must notify Us in writing when a company stops being an Affiliated Company. As of this date, this Contract will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Contractholder or another Affiliated Company as eligible Employees.

AMENDMENT

The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law,** it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Contractholder or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under this Contract is valid unless We consent thereto.

CLERICAL ERROR-MISSTATEMENTS

No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under this Contract will reduce a [Member's] Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are there-

by affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, [or the amount of coverage], subject to this Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Contract, [and in what amounts].

CONFORMITY WITH LAW

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONTRACT INTERPRETATION

We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

EMPLOYEE'S EVIDENCE OF COVERAGE

We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:

a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

In the event this Contract is amended, and such amendment affects the material contained in the evidence of coverage, a rider or revised evidence of coverage reflecting such amendment will be issued to the Contractholder for delivery to affected Employees.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a [Member]: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET

We reserve the right, before paying [Non-Network] benefits to a [Member], to use the amount of payment due to offset a [Non-Network] claims payment previously made in error.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

[Network] Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PARTICIPATION REQUIREMENTS

If this Contract provides coverage on a Non-contributory basis (the Contractholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. [If Dependent coverage is provided on a Noncontributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents.] If an eligible Employee is not covered by this Contract because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health Benefits Plan offered by the Contractholder,

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

If this Contract provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. [If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents.] If an eligible Employee is not covered by this Contract because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under any Health benefits Plan offered by the Contractholder,

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage provided under this Contract. Those charges are Determined from the Premium rates then in effect and the Employees and Dependents then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Contractholder and Us.

The following will apply if one or more Premiums paid include Premium charges for a [Member] whose coverage has ended before the due date of that Premium. We will not have to refund more than [the amount of (a) minus (b):

a) the amounts of the Premium charges for the [Member] that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contractholder that the [Member's] coverage has ended.
b) the amount of any claims paid or the value of any services provided to [Members] after their coverage has ended.]

PAYMENT OF PREMIUMS-GRACE PERIOD

Premiums are to be paid by the Contractholder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the **Schedule of Premium Rates and Classification** section of the Contract. We have the right to change Premium rates as of any of these dates:

a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) any date that the extent or nature of the risk under the Contract is changed:
   - by amendment of the Contract; or
   - by reason of any provision of law or any government program or regulation;
d) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

RECORDS-INFORMATION TO BE FURNISHED

We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to determine the premium rates and certify status as a Small Employer. All records of the Contractholder and of the Employer which bear on this Contract must be open to Us for Our inspection at any reasonable time.

We will not have to perform any duty that depends on such data before it is received in a form that satisfies Us. The Contractholder may correct wrong data given to Us, if We have not been harmed by acting on it. A person's coverage under this Contract will not be made invalid by failure of the Contractholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Contractor will furnish Us the Employee [and Dependents] eligibility requirements of this Contract that apply on the Effective Date. Subject to Our approval, those requirements will apply to the Employee [and Dependent] coverage under this Contract. The Contractholder will notify Us of any change in the eligibility requirements of this Contract, but no such change will apply to the Employee [or Dependent] coverage under this Contract unless approved in advance by Us.

The Contractholder will notify Us of any event, including a change in eligibility, that causes termination of a [Member's] coverage immediately, or in no event later than the last day of the month in which the event occurs. Our liability to arrange or provide benefits for a person ceases when the person's coverage ends under this Contract. [If the Contractholder fails to notify Us as provided above, We will be entitled to reimbursement from the Contractholder of any benefits paid to any person after the person's coverage should have ended.]

TERMINATION OF THE CONTRACT-RENEWAL PRIVILEGE

We have the right to cancel this Contract on any premium due date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves its principal place of business outside the State of New Jersey;
b) subject to the statutory notification requirements, We cease to do business in the small group market;
c) with respect to Contributory Contracts, less than [75%] of the eligible Employees are covered by this Contract. If an eligible Employee is not covered by this Contract because:
   - the Employee is covered as a Dependent under a spouse's coverage; or
   - the Employee is covered under an alternate Health Benefits Plan offered by the Contractholder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements; or

d) with respect to Non-contributory Contracts, less than [75%] of the eligible Employees are covered by this Contract. If an eligible Employee is not covered by this Contract because:
   - the Employee is covered as a Dependent under a spouse's coverage; or
   - the Employee is covered under an alternate Health Benefits Plan offered by the Contractholder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.

We have the right to cancel this Contract on any premium due date subject to 30 days advance written notice to the Contractholder for the following reason: During or at the End of Grace Period-Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Contract will automatically end when the period ends. But the Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid, or at any time during the grace period. Then this Contract will end on the date requested.

Immediate cancellation will occur if the Contractholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. All periods of coverage hereunder will begin and end at 12:01 a.m. Eastern Standard Time at the Contractholder's place of business.

The Contractholder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on any Contract Anniversary if the Contractholder is no longer a Small Employer.

The Contractholder must certify to Us its status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Contractholder fails to do this, We retain the right to take the actions described above as of the Contractholder's Contract Anniversary.

THE CONTRACT

The entire Contract consists of:

[a) the forms shown in the Table of Contents as of the Effective Date;
b)] the Contractholder's application, a copy of which is attached to the Contract;
[c)] any riders, [endorsements] or amendments to the Contract; and
[d)] the individual applications, if any, of all [Members].

Information in a Contractholder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to the Contractholder for attachment to this Contract.

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a [Member], and We furnish a copy to the [Member] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION

The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

A claimant's right to make a claim for any benefits provided by this Contract is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 day of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:

a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will determine to pay either the Member or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Contract to such provider.

PHYSICAL EXAMS

We, at Our expense have the right to examine the [Member]. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a [Member] is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a [Member] elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:

a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:

a) will not be entitled to duplicate benefits; and

b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;

b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:

a) an active, covered Employee;

b) the spouse of an active, covered Employee; or

c) the Dependent child of an active, covered Employee. Any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a) he or she was not terminated due to gross misconduct; and

b) he or she is not entitled to Medicare.

The continuation:

a) may cover the Employee and any other qualified continuee; and

b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and

b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered

If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or

b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:

a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

1) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
2) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
3) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

4) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
5) the date this Contract ends;
6) the end of the period for which the last premium payment is made;
7) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
8) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End

If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employer Must Do

At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:

a) his or her right to continue this contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation. The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed covered under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends

A [Member's] continued health coverage end on the first of the following;

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the [Member];
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the [Member], the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if excessive coverage exists using Our standards for excessive coverage; or
c) [• if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

RIGHT TO RECOVERY-THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Contract or arrange or provide services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:

a) a [Member], other than an Employee or covered spouse;
b) an Employee or covered spouse who is under age 65; or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare

When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)-The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B)-The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary

When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a [Member] who is:

a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:

a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare

When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. If he or she is not, with respect to [Non-Network] benefits, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD

When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and

b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, with respect to [Non-Network] benefits, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.

b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.

c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contract the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.

b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.

c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.200, effective April 15, 1996.
See: 28 N.J.R. 27(a), 28 N.J.R. 2042(a).

EXHIBIT II

Standard HMO/POS Evidence of Coverage

[INTRODUCTION]

What is a Point of Service Plan?

A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of **in-network providers** as well as the services of **out-of-network providers.** Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either an **in-network provider** (subject to any necessary authorization from his or her Primary Care Physician) or those of an **out-of-network provider**.

What is the difference between an in-network provider and an out-of-network provider?

An **in-network provider** is a doctor, other practitioner or facility that has an agreement with [Carrier] to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. An **out-of-network provider** is any licensed or certified provider that does not have a specific agreement with [Carrier].

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of an **in-network provider** rather than the services of an **out-of network provider**.

How does the POS plan describe in-network and out-of-network coverage?

The POS plan contains a section which describes in-network coverage and sections which describe out-of-network coverage. The POS plan also contains many sections which apply to both the use of the services of **in-network providers** or the services of **out-of-network providers**.

• **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment for use of an **in-network provider** as well as the deductible and coinsurance requirement for the use of an **out-of-network provider**. The **SCHEDULE** also identifies some limitations to coverage.

• **COVERED SERVICES AND SUPPLIES.** This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of an **in-network provider**.

• **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if he or she were to use the services of an **out-of-network provider**.

How does a person access in-network providers?

[Carrier] will provide a [directory] listing all the Primary Care Physicians and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Physician, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying [Carrier].

Except in case of a medical emergency, in-network services and supplies can **only** be provided by an **in-network provider (subject to any necessary authorization from his or her Primary Care Physician)**. [While certain routine OB/GYN care may be secured without going through the PCP, all other in-network services and supplies require the authorization of the PCP.]

How much will it cost for services and supplies if a person uses in-network providers?

[The Identification Card will specify the amount of the copayment the **in-network provider** will collect for most services and supplies.] For many services, after a person

pays a copayment for the PCP visit, further services and supplies require no additional payment. Home Health Care and Durable Medical Equipment are examples of such services and supplies. [Carrier elected to cover prescription drugs subject to the same coinsurance requirement as applies to out-of-network covered charges.] [Carrier elected to cover prescription drugs subject to a $[15] copayment.]

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of an out-of-network provider?

Persons covered under a POS plan may use the services of an out-of-network provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from [Carrier], as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses out-of-network providers?

After the payment of the applicable calendar year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit is the first out-of network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, [Carrier] would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a calendar year, further charges are only subject to the applicable coinsurance. **Note:** [Carrier] pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Reasonable and Customary Charge, as defined in the Contract and the Evidence of Coverage.

Does the POS plan cover the same services and supplies whether a person uses in-network providers or out-of-network providers?

The POS plan was designed to include the same services and supplies whether the person uses **in-network** or **out-of-network providers**. However, the **extent** of coverage differs for some services and supplies. For example, if a person elects to use an **in-network provider** for extended care services (skilled nursing care), coverage is unlimited as to number of days. If a person uses an **out-of-network provider**, extended care services are limited to 120 days.

Since in-network services and supplies must be coordinated by a PCP, and **in-network providers** are familiar with in-network covered services and supplies, the list of in-network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of network covered charges. In addition, [Carrier] is able to offer more details as to the nature and extent of the in-network coverage.

For services and supplies that are subject to limitations, can a person receive both in-network and out-of-network services and supplies?

The POS plan allows a person to receive any combination of in-network and out-of network services and supplies. However, for services and supplies subject to limitations, the POS plan includes offset provisions to coordinate the **total** services and supplies a person may receive.

PLEASE REFER TO THE CONTRACT [AND EVIDENCE OF COVERAGE] FOR COMPLETE INFORMATION CONCERNING THE POS PLAN AND USE OF IN-NETWORK AND OUT-OF-NETWORK PROVIDERS.

[Carrier] HMO—POS PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION POINT OF SERVICE EVIDENCE OF COVERAGE

[Carrier] certifies that the Employee named below is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

CONTRACT HOLDER:	[ABC Company]
GROUP CONTRACT NUMBER	[G-12345]
[EMPLOYEE	John Doe]
EVIDENCE OF COVERAGE NUMBER	[C-123456]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE:	[January 1, 1996]
SERVICE AREA	[State of New Jersey]
AFFILIATED COMPANIES:	[DEF Company]

[COST OF COVERAGE

The coverage described in this Evidence of Coverage is Contributory Coverage. You will be advised of the amount of Your contribution when You enroll.]

[Carrier's address

100 Main Street, Any Town, NJ 00000–0000]

HMO/POS-EOC

[All eligible employees]

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SCHEDULE OF CLASSIFICATION

The Contract's classification, and the coverages and amounts which apply to each class are shown below:

CLASS

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]

Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated below for Prescription Drugs]

[NON-NETWORK]

Cash Deductible (calendar year, all cause)	[$250, $500, $1000] per person [$500, $1000, $2000 per family] [Note: Must be individually satisfied by 2 separate [Members]]

Medicare Alternate Deductible

For a [Member] who is eligible for Medicare by reason of disability, but is not covered by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid if the [Member] had been so covered. After the 18 month period described in Medicare as Secondary Payor ends with respect to a [Member] who is eligible for Medicare solely on the basis of end stage renal Disease, but is not covered by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the [Member] been so covered.

Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] **[except as stated below]**
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	[25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS Unlimited, **except** as otherwise stated

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THE CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Hospital		
Inpatient (unlimited days)	[$150] Copayment/day; maximum/admission [$750]; maximum/cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit	Deductible/Coinsurance

SERVICES	[NETWORK]	[NON-NETWORK]
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment/visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment/visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	$50 Copayment/visit; credited toward Inpatient Copayment if admission occurs within 24 hours	$50 Copayment; waived
Maternity	$25 Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$15] Copayment/visit	See the Covered Charges
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Mental or Nervous Conditions and Substance Abuse	Inpatient: [$150] /Copayment day; maximum/admission [$750]; maximum/cal. year [$1500]; Maximum 30 days/ calendar year Outpatient: [$15] /Copayment visit; Maximum 20 visits/ calendar year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	Deductible/Coinsurance $5,000/calendar year; $25,000/lifetime maximum benefit for Inpatient and Outpatient care, combined
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment/visit	Deductible/Coinsurance
Prescription Drugs	at the option of the Carrier: [$15] Copayment per prescription; or the [Non-Network] Coinsurance	Deductible/Coinsurance
Home Health Care	Covered	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered	Deductible/Coinsurance; Subject to Pre-Approval
Podiatric Care	[$15] Copayment/visit	Deductible/Coinsurance

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits Applicable to [Non-Network] Benefits

During a Period of Hospital Confinement

For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, We will cover charges up to the Hospital's average semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the [Member] is being isolated in a private room because the [Member] has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

For Special Care Units, We will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement in an Extended Care Center or Rehabilitation Center

We will cover the lesser of:

a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:

accredited for its stated purpose by either the Joint Commission or the Accreditation for

a) ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contractholder through common ownership of stock or assets.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:

a) carry out its stated purpose under all relevant state and local laws; or

b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a Member. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. *NOTE: The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to [Non-Network] benefits. The services and supplies must be:

a) furnished or ordered by a health care Provider; and

b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by the Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

a) is furnished mainly to help a [Member] meet a [Member's] routine daily needs; or

b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[**DEPENDENT.** Your:

a) legal spouse;

b) unmarried Dependent child who is under age 19; and

c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of the Contract.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by the Contract as an Employee.

At Our Discretion, We can require proof that a person meets the definition of a Dependent.]

[**DEPENDENT'S ELIGIBILITY DATE.**

The later of:

a) Your Eligibility Date; or
b) the date the person first becomes a Dependent.]

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION/DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We [or the Care Manager]

Determine to be:

a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a [Member's] home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Contract for a Member.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] Determine are:

a) not of proven benefit for the particular diagnosis or treatment of a [Member's] particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member's] particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member's] particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a [Member's] particular condition, as explained below.

We [or the Care Manager] will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   a) The American Medical Association Drug Evaluations;

b) The American Hospital Formulary Service Drug Information; or
c) The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Center.

FACILITY. A place which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Contract.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A–19). Health Benefits Plan excludes the following plans, policies or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A–1 et seq.).

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] Practitioners provide Covered Services and Supplies to [Members].]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited as a hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a [Member]. A Mental or Nervous Condition is not an Illness.

[INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.]

INJURY. Damage to a [Member's] body due to accident, and all complications arising from that damage.

INPATIENT. Member, if physically confined as a registered bed patient in a Hospital or other health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under the Contract more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage [and Dependent Coverage] subsection[s] of the **Eligibility** section of the Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include, but are not limited to, heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] Determine to be:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

[MEMBER. An eligible person who is covered under the Contract [(]includes Covered Employee [and covered Dependents, if any)].]

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental or Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-COVERED CHARGES. Charges which do not meet the Contract's definition of Covered Charges or which exceed any of the benefit limits shown in the Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by the Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in the Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Contract.

OUTPATIENT. Member, if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We [or the Care Manager] Determine if the cause(s) of the confinements are the same or related.

PER LIFETIME. During the lifetime of an individual, regardless of whether he or she was covered under the Contract or any other contract, policy or plan:

a) as an Employee or Dependent; and
b) with or without interruption of coverage.

PRACTITIONER. A medical practitioner who:

a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Contract.

PRE-APPROVAL or PRE-APPROVED. Our written approval for specified services and supplies prior to the date the charges are incurred. Services or supplies for which the charges have not been pre-approved are not covered.

[PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before a [Member's] coverage under the Contract starts, and for which:

a) A [Member] sees a Practitioner , takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the [Member's] coverage starts; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a [Member's] coverage starts is also a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of the Contract for details on how the Contract limits the services and benefits for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:

a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
   - The American Medical Association Drug Evaluations;
   - The American Hospital Formulary Service Drug Information;
   - The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to [Network] services and supplies, the negotiated arrangement. With respect to [Non-Network] benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the [Non-Network] benefits under the Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the Care Manager] in conformance with Our policies and procedures that directs a [Member] to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer. State, county, or municipal bodies, agencies, boards or departments are not considered to be Small Employers for the purpose of the Contract.

SPECIAL CARE UNIT. A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or

b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

b) the correction of fractures and dislocations;

c) pre-operative and post-operative care; or

d) any of the procedures designated by Current Procedural Terminology codes as surgery.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy-the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy-the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy-retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment-the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy-the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy-treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy-the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy-the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy-the introduction of dry or moist gases into the lungs.

Speech Therapy-treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in the Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Employee.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

We will not cover an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

We will not cover You until the You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee's Eligibility Date, coverage will start on Your Employee's Eligibility Date.

If You enroll and agree to make the required payments, if any:

a) more than [30] days after Your Employee's Eligibility Date; or
b) after You previously had coverage which ended because You failed to make a required payment;

We will consider You to be a Late Enrollee. Late Enrollees are subject to the Contract's Pre-Existing Conditions limitation.

However, if You initially waived coverage under the Contract, and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under the Contract, We will not consider You to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a) termination of employment;
b) divorce;
c) death of Your spouse; or
d) termination of the other plan's coverage.

But, You must enroll under the Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date You become eligible.

[The Waiting Period

The Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Contract from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under the Contract from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier. You may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Contract's eligibility waiting period if:

a) You were employed by the Employer on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Multiple Employment

If You work for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Contract. But, if the Contract uses the amount of an Employee's earnings to determine class, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, We will postpone the start of Your coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments if any, within [30] days of Your Eligibility Date. If You do this within [30] days of Your Employee's Eligibility Date, Your coverage is scheduled to start on Your Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your coverage under the Contract will end on the first of the following dates:

a) [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] You stop being an eligible Employee under the Contract.
c) the date the Contract ends, [or is discontinued for a class of Employees to which You belong.]
d) the last day of the period for which required payments have been made for You, subject to the **Payment of Premium—Grace Period** section.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. The Contract's benefits provisions explain these situations. Read the Contract's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are:

a) Your legal spouse;
b) Your unmarried Dependent children who are under age 19; and
c) Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Eligible Dependents will not include any Dependent who is:

a) covered by the Contract as an Employee or
b) on active duty in the armed forces of any country.

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, Your step-children if they depend on You for most of their support and maintenance and children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past the Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached the Contract's age limit;
b) the child became covered under the Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Contract. We consider an eligible Dependent to be a Late Enrollee, if You:

a) enroll a Dependent [and agree to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible Dependents who You have not elected to enroll; or
c) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Contract's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Contract and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a) termination of employment;
b) divorce;
c) death of the Your spouse; or
d) termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, We will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Contract, to be a Late Enrollee, if:

a) You are under legal obligation to provide coverage due to a court order; and
b) You enroll Your spouse or eligible Dependent children, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

When Dependent Coverage Starts

In order for Your Dependent coverage to begin, You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below, and to all of the terms of the Contract, the date Your Dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the Dependent's Eligibility Date, or
b) the date You become covered for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date You sign the enrollment form; or
b) the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a) the date You notify Us [and agree to make any additional payments], or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, We will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility; or the day after home confinement ends.

Newborn Children

We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a) If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid][.] [and, in order to access [Network] services and supplies, You must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If You are not covered for Dependent child coverage on the date the child is born, You must:
   1) make written request to enroll the newborn child[; and
   2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the request is not made [and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends

A Dependent's coverage under the Contract will end on the first of the following dates:

a) [the date] Your coverage ends;
[b) the date You stop being a member of a class of Employees eligible for such coverage;]
[c)] the date the Contract ends;
[d)] the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
[e) the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.]
[f)] At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read the Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If the Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the Member.

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies, or charges incurred by other family members.

The extension ends on the earliest of:

a) the date the Total Disability ends;
b) one year from the date the person's coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

You must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the Member.
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN

A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In a Medical Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a [Member's] treatment for [a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the Member.]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The [Member] can select another Primary Care Physician from Our [Physician or Practitioners Directory].

[Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If We receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

IDENTIFICATION CARD

The Identification Card issued by Us to [Members] pursuant to the Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under the Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If You are the [Member] who misuses the card, coverage may be terminated for You as well as any of Your Dependents who are [Members]. To be eligible for services or benefits under the Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under the Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of the Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to the Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under the Contract, or similar causes, the rendition f medical or hospital benefits or other services provided under the Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

REFERRAL FORMS

A [Member] can be referred for Specialist Services by a [Member's] Primary Care Physician.

Except in the case of a Medical Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Physician (including, but not limited to, Specialist Services) if a [Member] has not been referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A [Member] may, for personal reasons, disagree or not comply with procedures, medicines, or courses of treatment recommended by a [Network] Practitioner or ignore treatment that is deemed Medically Necessary and Appropriate by a [Network] Practitioner. If such [Network] Physician (after a second [Network] Practitioner's opinion, if requested by [Member]), believes that no professionally acceptable alternative exists, and if after being so advised, [Member] still refuses to comply with or accept the recommended treatment or procedure, neither the Practitioner, nor We, or any [Network] Provider will have further responsibility to provide any of the [Network] services and supplies available under the Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to [Member] of a decision not to provide further [Network] services and supplies for a particular condition. The decision is subject to the Appeals Procedures. Treatment for the condition involved will be resumed in the event [Member] agrees to follow the recommended treatment or procedure. Note: While no [Network] services and supplies will be available, the [Member] may still be eligible for [Non-Network] benefits, subject to the terms and conditions of the Contract concerning [Non-Network] benefits.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a Member, such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, Covered Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and

information pertaining to the care, treatment and physical condition of [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under the Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP

a) No [Network] Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any [Network] Provider or other Provider, institution, Facility or agency.

b) Neither the Contractholder nor any [Member] is our agent, representative or employee, or an agent or representative of any [Network] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under the Contract.

c) [Network] Practitioners maintain the physician-patient relationship with [Members] and are solely responsible to [Members] for all medical services which are rendered by [Network] Practitioners.

d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

COVERED SERVICES AND SUPPLIES APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [or Coinsurance] as stated in the applicable Schedule.

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.

2) **Home visits** by a [Member's] Primary Care Physician.

3) **Periodic health examinations** to include:

- Well child care from birth including immunizations;
- Routine physical examinations, including eye examinations;
- Routine gynecological exams and related services;
- Routine ear and hearing examination; and
- Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).

4) **Diagnostic Services.**

5) **Casts and dressings.**

6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Physician and approved in advance by Us.

7) **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in the Contract.

8) **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.

9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.

10) **Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.

11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance by Us.

12) **Dental x-rays** when related to Covered Services.

13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]facilities upon prior written authorization by Us); however, [Network] Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

1. Semi-private room and board accommodations
   - As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
     - a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and
     - a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.
   - We provide such coverage subject to the following:
     - the attending Practitioner must determine that inpatient care is medically necessary; or
     - the mother must request the inpatient care.
   - [As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS.** The following Services are covered when rendered by a [Network] Provider at Provider's office or at a [Network] Substance Abuse Center [or Health Center] [upon prior Referral by a [Member's] Primary Care Physician] [or the Care Manager].

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member's] Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member's] Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** [Members] are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate, and only to the extent of the covered benefit as defined above.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS BENEFITS A [MEMBER] RECEIVES AS [NON-NETWORK] BENEFITS WILL REDUCE THE BENEFITS AVAILABLE AS [NETWORK] MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES.

(e) **EMERGENCY CARE BENEFITS-WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Physician in the event of a Medical Emergency as Determined by Us.

1) A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking emergency treatment.

2) We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior Referral only if:

- Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
- The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-emergency basis; and
- We and a [Member's] Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3) In the event [Members] are hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of the Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or [Members] shall be responsible for payment.

5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager].

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a [Network] Provider by a [Member's] Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a [Member's] Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a [Member's] condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy and Respiration Therapy.

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.

(g) **HOME HEALTH SERVICES.** The following services are covered when rendered by a [Network] Provider including, but not limited to, a [Network] Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a [Member's] Primary Care Physician [or the Care Manager].

1. **Skilled nursing services,** provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide,** under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a [Member's] medical condition.
4. **Therapy Services** as set forth above.
5. **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member's] Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our Determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing;
3) and all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(i) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ).** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j) **THERAPEUTIC MANIPULATION.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

[NON-NETWORK] BENEFIT PROVISION APPLICABLE TO [NON-NETWORK] BENEFITS

The Cash Deductible

Each Calendar Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by the Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that [Member] is covered by the Contract. And what We pay is based on all the terms of the Contract.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:

a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the Calendar Year in which the Contract starts;
b) the charges would have been considered Covered Charges under the Contract if the Contract had been in effect;
c) the [Member] was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit

The Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any [Member] of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of the Contract.]

[Per Family

The Per Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more [Members] in a family have incurred a combined total of Covered Charges toward their Per Person Cash Deductible equal to the per Family Cash Deductible, each [Member] in that family will be considered to have met his or her Per Person Cash Deductible for the rest of that Calendar Year. The Charges that each [Member] in a family may use toward the Per Family Cash Deductible may not exceed the amount of the Per Person Cash Deductible.]

Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a [Member] must incur each Calendar Year before no Coinsurance is required, **except as stated below.**

Exception: Charges for Mental or Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

COVERED CHARGES APPLICABLE TO [NON-NETWORK] BENEFITS

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of the Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced or eliminated if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in the Contract.

Hospital Charges

We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement.

As an **exception** to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:

a) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and

b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that in-patient care is medically necessary; or

b) the mother must request the in-patient care.

If a [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to the Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. The Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of the Contract.

Emergency Room Copayment Requirement

Each time a [Member] uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the [Member's] health.

Extended Care or Rehabilitation Charges

Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Home Health Care Charges:

Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Contract and to the following conditions:
   1) The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
      - ordered by the [Member's] Practitioner;
      - included in the home health care plan: and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
   2) The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.
   3) The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
   4) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   5) We do not pay for:
      - services furnished to family members, other than the patient; or
      - services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

Practitioner's Charges for Non-Surgical Care and Treatment

We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of the Contract.

Practitioner's Charges for Surgery

We cover Practitioner's charges for Medically Necessary and Appropriate Surgery. We do not pay for Cosmetic Surgery.

Second Opinion Charges

We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Member. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of the Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Contract. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:

a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

Alcohol Abuse

We pay benefits for the Covered Charges a [Member] incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:

a) a Hospital
b) a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

The Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

Birthing Center Charges

We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and postpartum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Anesthetics and Other Services and Supplies

We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But We do not pay for replacements or repairs.

Blood

We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Member.

Ambulance Charges

We cover Medically Necessary and Appropriate charges for transporting a [Member] to:

a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental.

But We do not pay for:

a) any purchases without Our advance written approval;
b) replacements or repairs; or
c) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor

We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Member. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of the Contract.

Nutritional Counseling

Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

X-Rays and Laboratory Tests

We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of the Contract.

Dental Care and Treatment

We cover:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

Mammogram Charges

We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of the Contract, and the following limitations:

We will cover charges for:

a) one baseline mammogram for a female Member, ages 35–39
b) one mammogram, every 2 years, for a female Member, ages 40–49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female [Member] ages 50 and older.

Private Duty Nursing Care

We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

We cover the following Therapy Services:

Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

We cover the Therapy Services listed below, subject to stated limitations:

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services

Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

Preventive Care

We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:

a) $500 per [Member] for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) $300 per [Member] for all other [Members].

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Vision Screening

We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation

We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Mental or Nervous Conditions and Substance Abuse

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A [Member] may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The [Member] must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit what We pay each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. We limit what We pay Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
   - Leukemia
   - Lymphoma
   - Neuroblastoma
   - Aplastic Anemia
   - Genetic Disorders
   - SCID
   - WISCOT Aldrich
   - Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which We do not Pre-Approve are not covered.]

[h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THE CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in the Contract, unless it is required as a result of an Illness or Injury sustained while covered under the Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in the Contract.

Care or treatment by means of dose **intensive chemotherapy**, except as otherwise stated in the Contract.

Services or supplies, the primary purpose of which is **educational** providing the [Member] with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or **Investigational** treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. except as otherwise stated in the Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of Your **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

Except as otherwise stated in the Contract, services or supplies related to **Hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Services or supplies related to **Hypnotism.**

Services or supplies because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment,** except as otherwise stated in the Preventive Care section of the Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;

a) insulin needles and insulin syringes and glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Contract. See the Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to Determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] coverage under the Contract starts, and for which:

a) a [Member] sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a [Member's] coverage starts is also a Pre-Existing Condition.

We do not pay benefits for charges for Pre-Existing Conditions until the [Member] has been continuously covered by the Contract for 180 days.

This limitation does not affect benefits for other unrelated conditions[, or birth defects in a covered Dependent child]. And We wave this limitation for a [Member's] Pre-Existing Condition if the condition was payable under another carrier's group plan which covered the [Member] right before the [Member's] coverage under the Contract started. The next section shows other exceptions.

Continuity of Coverage

A new [Member] may have been covered under a group or individual health insurance policy or contract delivered, or issued for delivery in the United States, including coverage by an insurance company, a health, hospital or medical service corporation, or health maintenance organization, Medicare or Medicaid or any other federally funded health benefits program, and with respect to a group plan, an employer-based self-funded or other health benefit arrangement, prior to enrollment under the Contract. When this happens, if the previous plan provided coverage for a condition, We give credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing, whether or not the previous plan paid benefits for the condition to the Member. We go back to the date his or her coverage under the previous plan started. But Your active Full-Time service with the Employer must start within 90 days of the date Your coverage under the previous plan ended. And You must sign and complete Your enrollment form within 30 days of the date Your active Full-Time service begins. Any condition arising between the date Your coverage under the previous plan ends and the date Your coverage under the Contract starts is Pre-Existing. We do not cover any charges actually incurred before Your coverage under the Contract starts. If the Employer has included an eligibility waiting period in the Contract, You must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** except as specified in the Contract.

With respect to [Non-Network] benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of the Contract.

Services or supplies that are not furnished by an eligible **Provider**.

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to [Network] services and supplies provided in the event of a Medical Emergency, and with respect to all [Non-Network] benefits.

Services or supplies related to **rest or convalescent cures**.

Room and board charges for a [Member] in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of the Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except**:

a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a) eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;
e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:
   - travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
   - business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and

- Subject to Our Pre-Approval, full-time student status, provided the [Member] is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker**, except as otherwise stated in the Contract.

Stand-by services required by a Provider.

Sterilization reversal-services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member's] sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

[IMPORTANT NOTICE APPLICABLE ONLY TO [NON-NETWORK] BENEFITS

[The Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a Member:

a) is admitted as an Inpatient to a Hospital, or

b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under the Contract. See the **Utilization Review Features** section for details.]

[The Contract has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a [Member's] medical needs in clinical situations with the potential for catastrophic claims to Determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of the Contract. Read the Contract carefully and keep it available when consulting a Practitioner.

If You have any questions after reading the Contract You should [call The Group Claim Office at the number shown on Your Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with the Contract's utilization review features, he or she will not be eligible for full benefits under the Contract.

Compliance with the Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under the Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Contract.

Definitions

"Hospital admission" means admission of a [Member] to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the [Member's] condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the [Member's] life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Contract is not payable under the Contract.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a [Member] is not satisfied with a utilization review decision, the [Member] or the [Member's] Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This Practitioner will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the [Member's] Practitioner. The [Member's] Practitioner is then notified of the appeal's recommendation and referred to Us for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Contract.

Notice of Hospital Admission Required

We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The [Member] or the [Member's] Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a [Member] or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:

a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission;
d) the name and location of the Hospital;
e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review

The [Member] or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Member, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the [Member's] Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, **by 50%**] if:

a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges **by 50%**], if:

a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet the Contract's:

a) Cash Deductible; or
b) Coinsured Charge Limit.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Contract.

We require a [Member] to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The [Member] or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] must obtain a second surgical opinion in order to get full benefits under the Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Member. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of the Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:

a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Contract's:

a) Cash Deductible; or
b) Coinsured Charge Limit.

[ALTERNATE TREATMENT FEATURES

Important Notice: No [Member] is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a) They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a [Member] in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under the Contract.

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury Determined by [DEF] or Us to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Member, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a) the Member, or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Alternate Treatment Plan includes:

a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; Member; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Contract.

The agreed upon alternate treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that We [or the Care Manager] Determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to Determine whether the [Member] is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be considered as Covered Charges, the Center of Excellence must:

a) perform a Pre-Treatment Screening Evaluation; and
b) Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Member.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Contract. However, the Utilization Review Features will not apply.]]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A [Member] may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by the Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) Group or group-type hospital indemnity benefits;
d) Supplemental Limited Benefits Insurance coverages; nor
e) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.

b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:

a) while occupying, entering, leaving or using an automobile; or

b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a) the Contract;

b) PIP; or

c) OSAIC.

"Eligible Services or Expenses" means that of service or expense provided for treatment of an Injury which is covered under the Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

The Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under the Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

If there is a dispute as to which policy is primary, the Contract will pay benefits or provide services as if it were primary.

Services and Benefits the Contract will provide if it is primary to PIP or OSAIC.

If the Contract is primary to PIP or OSAIC it will provide **services and** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:

a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.

If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

Medicare

If the [Non-Network] benefits under the Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AMENDMENT

The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under the Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under the Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of the Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Contractholder or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under the Contract is valid unless We consent thereto.

CLERICAL ERROR-MISSTATEMENTS

No clerical error by the Contractholder or by Us in keeping any records pertaining to Coverage under the Contract will reduce a [Member's] Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, [or the amount of coverage], subject to the Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Contract, [and in what amounts].

CONFORMITY WITH LAW

Any provision of the Contract which, on its Effective Date, is in conflict with the *statutes* of the State of New Jersey, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under the Contract.

CONTRACT INTERPRETATION

We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under the Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a Member: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET

We reserve the right, before paying [Non-Network] benefits to a Member, to use the amount of payment due to offset a [Non-Network] claims payment previously made in error.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in the Contract, its riders and attachments. We have no other liability.

[Network] Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates, or appropriate employees or companies in administering the Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under the Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a Member, or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

THE CONTRACT

No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the [Member] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION

The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

A claimant's right to make a claim for any benefits provided by the Contract is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 day of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:

a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Contract to such provider.

PHYSICAL EXAMS

We, at Our expense have the right to examine the Member. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under the Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of the Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)**: If a [Member] is eligible to continue his or her group health benefits under both the Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of the Contract:

If a [Member] elects to continue his or her group health benefits under both the Contract's CCR and any other continuation sections, the continuations:

a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Member:

a) will not be entitled to duplicate benefits; and

b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. You must contact Your Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
b) the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Contract as:

a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Any person who becomes covered under the Contract during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a) You were not terminated due to gross misconduct; and
b) You are not entitled to Medicare.

The continuation:

a) may cover You and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and
b) 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered

If you die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Contract, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a) Your legal divorce or legal separation from Your spouse; or
b) the loss of dependent eligibility, as defined in the Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a) his right to continue the Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a) the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:

a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under the Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

1) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
2) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
3) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
4) with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
5) the date the Contract ends;
6) the end of the period for which the last premium payment is made;
7) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

8) the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read the Contract's **Conversion Rights for Divorced Spouses** section for details.

Important Notice

If An Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents,You must elect to continue health coverage for Yourself.

What The Employer Must Do

At the time of termination of employment or reduction of work hours, the Employer must notify You, in writing, of:

a) Your right to continue the Contract's group health benefits;
b) the monthly premium You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under the Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Contract on a regular basis. Any modifications made under the Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for You to continue.

When Continuation Ends

A [Member's] continued health coverage end on the first of the following;

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under the Contract on a regular basis, on the date

each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if You stop paying;
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Contract ends or is amended to end for the class of Employees to which You belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. You must contact Your Employer to find out if:

a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to You.

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a) the date You return to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period;
c) the date on which Your coverage would have ended had You not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were covered under the Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a) 180 days following the date of Your death; or
b) the date the Dependent is no longer eligible under the terms of the Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for Your former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [•if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under the Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.]

RIGHT TO RECOVERY-THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by the Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under the Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under the Contract or arrange or provide services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:

a) a Member, other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare

When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)-The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Contract is Primary** section below, for details.

Option (B)-The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had chosen Option (A).

When the Contract is primary

When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a [Member] who is:

a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:

a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare

When a [Member] becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Contract is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. If he or she is not, with respect to [Non-Network] benefits, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD

When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, with respect to [Non-Network] benefits, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all plan participants shall be entitled to:

a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contract the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90–day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.
c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
   - the specific reason(s) the claim is denied;
   - specific references to the pertinent plan provision on which the denial is based;
   - a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
   - and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.199, effective April 15, 1996.
See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(a).

EXHIBIT JJ

EXPLANATION OF BRACKETS—HMO POINT OF SERVICE CONTRACT AND EVIDENCE OF COVERAGE

All text which is enclosed in brackets is variable. Such text may generally be categorized in five ways.

Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].

1) Some areas of variability are noted with brief explanations within the text.
2) Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices
3) Some areas of variability are subject to ranges specified in statute or regulation.
4) Some areas of variability are determined by Carrier elections. [Examples include the use of a care manager, health center, and terms to identify the member, network and non-network benefits.]

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

1) The forms define and use the terms "Network" or "In-Network" and "Non-Network" or "Out-of-Network." Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms. (Example: Participating, Non-Participating)
2) The forms define and use the term "Member." Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
3) The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
4) Copayment, deductible and coinsurance amounts may be elected by the Contractholder, subject to the availability specified in regulation. (Example: "Non-Network options are consistent with the options set forth in Exhibits C and D of the Appendix to N.J.A.C. 11:21.")
5) The "Actively at Work" requirement may be deleted.
6) Carriers that do not use a "Care Manager" should omit the definition of Care Manager, and omit the term as it appears throughout the text.
7) The definition of "Employer" should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
8) Carriers that do not use "Health Care Centers or Health Centers" should omit the definition of Health Care Centers or Health Centers, and omit the terms as they appear throughout the text.
9) The "Waiting Period" provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed six months, as set forth in N.J.A.C. 11:21–7.9(c). (Contract Only)
10) The date employee or dependent coverage ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may end immediately, or at the end of the month in which the termination event occurs.)
11) The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration.
12) Carriers that do not have a home care program that satisfies the requirements of the New Jersey "48 hour maternity" statute, (P.L. 1995, c.138) should omit the reference to such program in the text of the Inpatient Hospice, Hospital, Rehabilitation Center and Skilled Nursing benefits section of the plan.
13) Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note:* All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
14) Carriers may elect to calculate the family deductible as two times the individual deductible, calculated on a per individual basis, or as three times the individual deductible, calculated on an aggregate basis. The Schedule and the Non-Network Benefit provision must reflect the selected calculation. *Note:* All plans issued by a Carrier must reflect the same election.
15) The Pre-Existing Conditions exclusion may be omitted.
16) The Utilization Review features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Banking and Insurance, pursuant to N.J.A.C. 11:21–4.2.

17) The "Alternate Treatment Feature" provision may be omitted. Carriers may provide for such "case management" administratively. If included in the form, the text must conform to the text of the standard form.

18) The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.

19) The "Small Claims Waiver" section of the "Coordination of Benefits" provision may be omitted.

20) The refund formula specified in the "Premium Amounts" provision may be modified to specify alternate methods of calculation. (Contract Only)

21) Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21–7.6.

22) The "Notice of Loss" section of the "Claims Provision" may be omitted, at the option of the Carrier.

23) The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.

24) Carriers may elect to omit the ERISA provisions.

The following explanations apply only to the Evidence of Coverage.

1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.

2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.

3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT KK

(Fill out this form if company reported Accident and Health Premium to the New Jersey Department of Banking and Insurance for a calendar year but did not have in force health benefits plans covering small employers, whether written directly or through an association, trust or multiple employer arrangement. See definitions in N.J.A.C. 11:2–1.2. If company had in force health benefits plans in the calendar year, fill out Market Share Report, "Exhibit CC." Filing due before March 1)

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM CERTIFICATION OF NON–MEMBER STATUS FOR CALENDAR YEAR___

Carrier Name _____
Address _____
_____
NAIC # _____

I, _____(print or type name)_____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK EITHER #1 OR #2)

___ 1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21–1.2; or

___ 2. Is a carrier that is not a "member" of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" in force in _____ (year) covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21–1.2. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for the stated year were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above (YOU MUST, IN THE SPACE BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 984–2425)

Signature of officer _____ Date _____
Title _____ Telephone Number _____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health Benefits Program
CN 325
Trenton, NJ 08625

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).