

- 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 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 proce-

dures 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).

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

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

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

- for Preventive Care None
 - for immunizations and lead screening for children None
 - For all other Covered Charges
 - 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] [\$750, \$1,500, or \$3,000]

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] [\$9,000]

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

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental or 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 not confined as a registered bed patient in a Hospital or recognized health care facility and is not an Inpatient, or services and supplies provided in such settings.

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.

[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 [Carrier].]

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).
 Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
 See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT C

SCHEDULE OF INSURANCE AND PREMIUM RATES

[PLAN C]

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 Preventive Care None
 - for immunizations and lead screening for children None
 - for all other Covered Changes
 - 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]] [\$750, \$1,500 or \$3,000]

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.

Co-Insurance Caps

Per Covered Person per each Calendar Year \$2,500
 [Per Covered Family per each Calendar Year [\$5,000] [\$7,500] [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 or 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 not confined as a registered bed patient in a Hospital or recognized health care facility and is not an Inpatient, or services and supplies provided in such settings.

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.

[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 [Carrier].]

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).
 Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
 See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

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

- for Preventive Care None
- for immunizations and lead screening for children None
- for all other Covered Charges

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]] [\$750, \$1,500 or \$3,000]

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 20%, except as stated below
Exception: for Mental or 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]] [\$6,000]

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

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental or 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 not confined as a registered bed patient in a Hospital or recognized Health Care Facility and is not an Inpatient, or services and supplies provided in such settings.

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

[Carrier] provides such coverage subject to the following:

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

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).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

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	
• for Preventive Care	None
• for immunizations and lead screening for children	None
• for all other Covered Charges	
Per Covered Person	\$150
[Per Covered Family	[\$300] [Note: Must be individually satisfied by 2 separate Covered Persons]] [\$450]

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] [\$4,500]

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

- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental or 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 not confined as a registered bed patient in a Hospital or recognized health care facility and is not an Inpatient, or services and supplies provided in such settings.

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"]