CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17B:27A–2 et seq.

Source and Effective Date

Adopted Concurrent Proposal, R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993.
See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Executive Order No. 66(1978) Expiration Date

Chapter 20, Individual Health Coverage Program, expires August 13, 1998.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993, set to expire August 13, 1993. See: 25 N.J.R. 2945(a). Chapter 20 was readopted by R.1993 d.439. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

11:20–1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A–2 et seq.), the Individual Health Insurance Reform Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A–2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A–2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).
Petition for Rulemaking: Exhibits A through F.
See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).

11:20–1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A–2 through 16).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in New Jersey. Carriers that are affiliated carriers shall be treated as one carrier.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or

2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person is a resident of New Jersey who is not eligible to be insured under a group health benefits plan or Medicare.

"Expenses" means a carrier's actual expenses including commissions to licensed insurance producers calculated on an incurred statutory basis and allocated on a consistent basis to individual lines, or a maximum of 25 percent of net earned premium, whichever amount is less.

"Family unit" means one person; a legally married man and woman; a legally married man and woman and their dependent child(ren) who are members of the same household; an adult and his or her dependent child(ren) who are members of the same household; and one or more dependent children under the age of 19 who are members of the same household.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93–222 (42 U.S.C. § 300e et seq.).

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

"Health benefits plan" means a hospital and medical expense insurance policy, including certificates covering individual New Jersey residents, a health service corporation subscriber contract or a health maintenance organization enrollment contract delivered or issued for delivery in New Jersey. The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;

2. Closed blocks of business otherwise meeting the definition of health benefits plan;

3. Executive medical plans;

4. Student coverage which provides more than accident-only coverages;

5. All prescription drug plans whether or not written on a stand alone basis;

6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; and

7. All other health policies, plans or contracts not specifically excluded.

The term "health benefits plan" specifically excludes:

1. Accident-only coverage;

2. Credit insurance;

3. Disability insurance;

4. Long-term care coverage;

5. Coverage arising out of a worker's compensation or similar law;

6. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A–1 et seq.;

7. Medical coverage provided as part of a liability policy;

8. Medical coverage provided as a rider to a non-medical benefits plan, wherein the medical coverage constitutes less than five percent of the premium for the benefits plan, including riders, and therefore is an incidental part of the benefits plan's coverage;

9. Hospital confinement indemnity coverage so long as the coverage is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than $40.00 but no more than $250.00 in daily benefits except that the benefit for the first day of hospital confinement may exceed $250.00 as long as the following formula is satisfied:

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} < \$250.00$$

10. Dental plans, whether or not written on a stand alone basis;

11. Vision care plans, whether or not written on a stand alone basis;

12. Reinsurance;

13. Coverage for Medicaid services provided pursuant to a contract with the State of New Jersey;

14. Medicare risk and cost contracts as defined in this section;

15. Coverage which is specifically advertised, marketed and designed to supplement CHAMPUS;

16. Medicare supplement coverage to the extent that such coverage meets the requirements of N.J.A.C. 11:4–23, Minimum Standards for Medicare Supplement Coverage, and is coverage that is reported on the Medicare Supplement Insurance Experience Exhibit of the NAIC Annual Statement blank for Life and Accident and Health Insurance or Health Maintenance Organizations; and

17. Self-funded arrangements for which revenue is not included as premium for statutory reporting purposes.

"HealthStart Plus" means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c.187, s.25 (N.J.S.A. 26:2H–18.47).

"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term "individual health benefits plan" shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student; an unemployed individual or part-time employee, except as may be provided pursuant to N.J.S.A. 17B:27A–17 et seq. and N.J.A.C. 11:21–7.3; a self-employed person; an employer, when he or she (and dependents) is the only person seeking coverage, except as may be provided pursuant to N.J.S.A. 17B:27A–17 et seq. and N.J.A.C. 11:21–7.6; any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A–17 et seq. and N.J.A.C. 11:21–7.6; a husband and wife who have their own business, if one spouse is seeking coverage as a dependent of the other rather than as a separate employee; and an employee who is one of several employees of the same employer who are covered by certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is established or adopted by two or more employers, by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or organizations provided such arrangement qualifies as an employee welfare benefit plan that is exempt from state insurance regulation pursuant to the Employee Retirement Income Security Act, 29 U.S.C. 1001 et seq.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D–1 et seq.) and amendments thereto.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89–97 (42 U.S.C. § 1395 et seq.) and amendments thereto.

"Medicare cost and risk contracts" means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans in New Jersey.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but with differentiation by health status.

"NAIC" means the National Association of Insurance Commissioners.

"Net earned premium" means the premiums earned in New Jersey on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net earned premium" shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. "Net earned premium" shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangement for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and

2. The per person limit is no less than $25,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 110 percent of expected claims.

"Non-group persons" include individually enrolled persons, persons covered by conversion policies issued pursuant to the Act, Medicare cost and risk lives and Medicaid and HealthStart Plus recipients.

"Open enrollment" means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis.

"Pre-existing condition" means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

"Public Advocate" means the New Jersey Department of the Public Advocate, Division of Rate Counsel.

"Reasonable and customary" means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey for various medical services and supplies, published and available from the Health Insurance Association of America.

"Reimbursement for losses" means reimbursements distributed through the IHC Program to cover losses, in whole or in part, incurred by members applying for reimbursements with respect to individual standard health benefits plans beginning in calendar year 1993 and thereafter.

"Resident" means a person whose primary residence for the majority of a year is in the State of New Jersey.

"Standard health benefits plan" means a health benefits plan, including riders, if any, adopted by the IHC Program Board.

Amended by R.1994 d.54, effective December 30, 1993.
See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).
Amended by R.1995 d.37, effective December 20, 1994.
See: 27 N.J.R. 41(b), 27 N.J.R. 371(b).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended "Eligible person" and "Family unit".

11:20–1.3 Closing of noncomplying individual health benefits plans

(a) Carriers may begin to market individual standard health benefits plans as defined at N.J.A.C. 11:20–3 on or after July 1, 1993, but not before; those standard health benefits plans shall not have a coverage effective date prior to August 1, 1993. All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with this chapter.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26–1 et seq., N.J.S.A. 17:48E–1 et seq., N.J.S.A. 26:2J–1 et seq. and rules promulgated pursuant thereto.

11:20–1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, including individual standard health benefits plans, shall be subject to the Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by the Act.

11:20–1.5 Penalties

Failure of a carrier to comply with any provision of this chapter may result in the carrier's losing its authority to write health benefits in New Jersey and imposition of any and all penalties and actions available under law.

11:20–1.6 Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM TEMPORARY PLAN OF OPERATION

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), and 17B:27A–2 et seq., as amended by P.L. 1993, c.164, section 7.

Source and Effective Date

R.1993 d.550, effective October 14, 1993.
See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

11:20–2.1 Purpose and structure

(a) The "IHC Program," created pursuant to the N.J.S.A. 17B:27A–2 to 16, amended by P.L. 1993, c.164, has as its members all insurance companies, health service corporations and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A–13 and for calendar years ending December 31, 1993 and thereafter pursuant to N.J.S.A. 17B:27A–12.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program Temporary Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law. The Commissioner has adopted the Temporary Plan of Operation pursuant to N.J.S.A. 17B:27A–10e as amended by P.L. 1993, c.164, section 5 and the Temporary Plan will continue in effect until amended or rescinded by the Commissioner.

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to N.J.S.A. 17:22A–1 et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the Temporary Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

(g) The IHC Program shall continue in existence subject to termination in accordance with the laws of this State or of the United States. In the event of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the IHC Program, the IHC Program shall terminate and conclude its affairs. Any funds or assets held by the IHC Program following the payment of all claims and expenses of the IHC Program shall be distributed to the member carriers at that time and in accordance with the then existing assessment formula.

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the following address:

New Jersey Individual Health Coverage Program
20 West State Street, 10th Floor
CN 325
Trenton, NJ 08625
Telephone (609) 633–1882
Fax (609) 633–2030

Administrative Change.
See: 27 N.J.R. 1423(a).

11:20–2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–2 as amended by P.L. 1993, c.164, and N.J.A.C. 11:20–1, when used in this subchapter, shall have the meanings as defined therein, 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:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof, policy form filings, rate filings, evaluation of material submitted by carriers with respect to loss ratios, and establishment of refunds to policyholders or contract holders; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Basic health benefits plan" means the health benefits plan designed by the Board in accordance with N.J.S.A. 17B:27A–4c as amended by P.L. 1993, c.164, section 3.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A–12a(3) and N.J.A.C. 11:20–11.

"Director" means a Director of the Individual Health Coverage Program who:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;

2. Has been appointed by the Governor and confirmed by the Senate; or

3. Sits ex officio on the Board of Directors, as applicable, in accordance with N.J.S.A. 17B:27A–10 as amended by P.L. 1993, c. 164, section 5.

"Financially impaired" means a carrier which, after the effective date of the Act, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations; or a carrier which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J–1 et seq.

"Plan" means the plan of operation of the IHC Program.

"Reasonable administrative expenses" means actual expenses, including commissions, or a maximum of 25 percent of premium (including commissions), whichever amount is less.

"Standard health benefits plan" means a health benefits plan, including the basic health benefits plan, adopted by the IHC Program board.

"Temporary Plan" means the temporary plan of operation for the IHC Program adopted by the Commissioner in accordance with N.J.S.A. 17B:27A–10 as amended by P.L. 1993, c.164, section 5.

11:20–2.3 Powers of the IHC Program and Board

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

(b) The Board shall have the power to do the following:

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and this Temporary Plan;

2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;

3. Establish standard policy forms for standard health benefits plans and rider packages;

4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to N.J.S.A. 17B:27A–4 as amended by P.L. 1993, c.164, section 3;

5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;

6. Review rate applications and form filings submitted by carriers in accordance with the Act and this Temporary Plan;

7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A–4 as amended by P.L. 1993, c.164, section 3;

8. Promulgate, in conjunction with the New Jersey Small Employer Health Benefits Program, a standard claim form for the standard health benefits policies;

9. Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;

10. Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

11. Appoint from among its members appropriate legal, actuarial and other committees necessary to provide technical and other assistance in the operation of the IHC Program, in policy and other contract design and any other functions within the authority of the Board;

12. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Temporary Plan;

13. Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

14. Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

15. Establish rules, conditions and procedures pertaining to the sharing of IHC Program losses and administrative expenses among the members of the IHC Program;

16. Calculate assessments and assess member carriers their proportionate share of IHC Program losses and administrative expenses in accordance with N.J.S.A. 17B:27A–12 and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

17. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

18. Impose interest penalties upon members for late payment of assessments;

19. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

20. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

21. Pursuant to P.L. 1993, c.164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of N.J.S.A. 17B:27A–2 through 16;

22. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

23. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under N.J.S.A. 17B:27A–2 et seq. as amended.

11:20–2.4 Temporary Plan of Operation

(a) The Temporary Plan shall become effective upon adoption by the Commissioner and submission of final action to OAL for publication. The Commissioner may amend the Temporary Plan by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A–10(d) and (e) as amended by P.L. 1993,

c.164, section 6, the Commissioner shall amend or rescind the Temporary Plan.

11:20–2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan. One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL–CIO, who has experience in the management or administration of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the population in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) A health service corporation;

(2) A health maintenance organization;

(3) A mutual insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes; and

(4) A foreign health insurance company authorized to do business in this State.

ii. The initial term of Directors representing carriers shall be determined by vote of the members of the IHC Program.

iii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated.

(3) At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) Affiliated carriers shall have no more than one vote for each position subject to vote.

(5) Elections shall be by a simple majority of those ballots properly cast in person and absentee.

(6) The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:20–2.9.

iv. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any, and the means by which Directors may be contacted during normal business hours by IHC Program members.

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair and Secretary from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;

2. Adopt a schedule of regular meetings for the year;

3. Appoint Directors and other persons to committees of the Board;

4. Ratify the budget; and

5. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

1. Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in (d)2 below.

2. The affirmative votes of five Directors shall be required to act upon the following:

i. Amendments to the Plan of Operation;

ii. Amendments to the standard health benefits plans;

iii. Adoption of any actions, as defined by P.L. 1993, c.164, sections 7 and 8, or amendments to the actions of the IHC Program;

iv. Removal of any Director from membership on any committee;

v. Recommendations by the Board to the Legislature regarding amendments to the Act; and

vi. An assessment or interim assessment.

(e) All meetings of the Board, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4–6 to 21.

(f) In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

(g) Directors shall not receive compensation for attendance at Board and Committee meetings. Directors may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

(h) The Board shall hold meetings either in person or by teleconference.

(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors and two copies to the Commissioner. The Board shall retain the original of the minutes.

1. The Secretary shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

i. The time, date and place of the meeting;

ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;

iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;

iv. The recorded votes of each member on each matter including abstentions;

v. The complete text of any resolutions adopted by the Board;

vi. As attachments, the agenda for the meeting and accompanying materials; and

vii. Any other information required to be shown in the minutes by law.

11:20–2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors and IHC Program members. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;

2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;

3. Abolish any standing committee;

4. Remove any person, other than a Director, from any standing committee at any time, with or without cause; and

5. Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

i. Methods for calculating assessments;

ii. Standards for information requested for rate filings and for review of such rate filings;

iii. Standards of review of loss ratios and incurred losses;

iv. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;

v. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time;

vi. Conditional and final exemptions from assessments;

vii. Whether acts of members are not in compliance with the Act and any rules promulgated thereunder;

viii. Reviews of informational rate filings submitted to the Board pursuant to N.J.A.C. 11:20–6;

ix. Whether an informational rate filing is complete;

x. Reviews of loss ratio reports submitted to the Board pursuant to N.J.A.C. 11:20–7;

xi. A member carrier's plan for refunds to policy and contract holders, if necessary;

xii. Any other reports or recommendations to the Board as may be appropriate regarding rates, rate filings and loss ratio reports; and

xiii. Reviews of assertions of non-member status.

2. A Legal Committee, which shall make reports to recommendations to the Board with respect to:

i. Rules to be promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;

iii. Any proposed amendments to the Act;

iv. Contracts and legal documents for the IHC Program;

v. All litigation and other disputes involving the IHC Program and its operations;

vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and

vii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member.

3. A Marketing and Communications Committee, which shall make recommendations to the Board with respect to:

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of individual health benefits plans to eligible persons;

ii. Marketing and communication plans for the IHC Program, as needed;

iii. Rules to determine "good faith" marketing efforts by members applying for exemptions;

iv. The insurance producer to be appointed by the Board pursuant to N.J.S.A. 17B:27A–10g, and assist in liaison efforts between the Board and the appointed producer; and

v. A buyers' guide to be distributed to consumers which describes the individual health benefits plans available to eligible persons pursuant to the Act.

4. A Forms Committee, which shall make recommendations to the Board with respect to:

i. Reviews of policy forms submitted to the Board pursuant to N.J.A.C. 11:20–3.2 and application forms submitted to the Board pursuant to N.J.A.C. 11:20–4;

ii. The disapproval of any policy form or application form that is not in substantial compliance with the Act and the Board's rules;

iii. Changes to the Board's standard policy forms, application form and claim form and develop new forms as may be necessary from time to time; and

iv. Whether acts of members are in compliance with the Act and any rules promulgated thereunder.

5. An Operations Committee, which shall make recommendations to the Board with respect to:

i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;

ii. The Plan of Operation and amendments thereto;

iii. Standards of acceptability for the selection of auditing firms;

iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary; and

v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan.

6. A Complaint Committee, which shall make recommendations to the Board with respect to:

i. Consumer, policyholder and member carrier inquiries, complaints and disputes arising in connection with the IHC Program;

ii. The manner by which the Board may address inquiries, complaints and disputes brought to its attention;

iii. Procedures for receiving, logging and handling inquiries, complaints and disputes;

iv. The design of inquiry, complaint and dispute forms;

v. Procedures for making inquiries and complaints and for carriers to use in notifying the Board of complaints and disputes; and

vi. Whether and how to respond to interpretations of the Board's rules made by member carriers and inquiries and complaints received from consumers, policyholders, member carriers or others.

(1) Recommendations by the Complaint Committee may include requesting that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Complaint Committee or Interim Administrator or subsequently appointed Administrator may seek the input of another appropriate Committee in order to assist the Complaint Committee in reaching a recommendation.

(3) The Complaint Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

(4) The Complaint Committee or Interim Administrator or subsequently appointed Administrator may compile statistics on complaints, disputes and appeals received and resolved and submit an annual report to the Board and the Commissioner detailing the volume of complaints, disputes and appeals categorized by type, carrier and disposition.

(5) Nothing contained in this paragraph shall be deemed to impair or otherwise affect the authority of the Commissioner to investigate and resolve any complaint or dispute or to take any regulatory or enforcement action with respect to any violations of any State insurance statutes or rules which come to the Commissioner's attention.

(e) The Board may by resolution establish and appoint other committees.

11:20–2.7 Financial administration

(a) The fiscal year of the IHC Program shall run from July 1 to June 30 of each year.

(b) All funds of the IHC Program shall be deposited and disbursements made from the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget.

1. Monies pertaining to the IHC Program shall be deposited into a dedicated account within the State's General Fund.

2. Monies may be credited from the General Fund to IHC bank accounts upon request by the Board through the Department, which request shall include justification for the request with supporting documentation, and shall be pursuant to the approval of the Director of the Division of Budget and Accounting.

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the IHC Program and shall be applied to reduce future assessments of members for IHC Program losses and administrative expenses, except as provided in N.J.A.C. 11:20–2.11(g) and 2.12(h).

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Interim Administrator or subsequently appointed Administrator to make disbursements of less than $1,000 per disbursement for administrative purposes subject to such conditions as the Board may prescribe.

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. The receipt and disbursement of cash for the IHC Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the IHC Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the IHC Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and this Temporary Plan, which records shall include at least the following:

i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;

ii. Any adjustments as set forth in this Plan;

iii. Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which shall be used to produce the IHC Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledger journals.

(f) The Interim Administrator or subsequently appointed Administrator shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by September 30 of each year beginning in 1994. The annual report shall fairly present the financial condition of the IHC Program for the preceding fiscal year.

1. All accounts shall be reconciled and trial balances shall be determined monthly.

2. Financial statements in a form approved by the Board shall be prepared and delivered to each member of the Technical Advisory Committee and the Commissioner on a quarterly basis.

11:20–2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. The auditor shall be selected and approved by the Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform audits of the type of entity.

2. The annual audit shall include the following items:

i. A review of the handling and accounting of assets and monies of the IHC Program;

ii. A determination that administrative expenses have been properly allocated and are reasonable;

iii. A review of the internal financial controls of the IHC Program;

iv. A review of the annual financial report of the IHC Program; and

v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.

3. A copy of the annual audit and related management letters shall be delivered to each Director and to the Commissioner. The annual audit report shall be reviewed by the Technical Advisory Committee, which shall present its recommendations to the Board for implementation of findings and recommendations made by the auditor. The actions adopted shall be reported to the Commissioner.

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

11:20–2.9 Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Interim Administrator or subsequently appointed Administrator.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules, including rate and form filings, loss ratio filings, reports of net earned premium and reports of net paid losses;

4. The rulemaking file on rules proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Determinations on requests for exemption by carriers;

8. All dispositions on matters of complaints and disputes;

9. Other actions by the Board required by the Act; and

10. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right–To–Know" Act, N.J.S.A. 47:1A–1 et seq., except that information in filings determined by the Board by regulation to be confidential and proprietary shall not be subject to public inspection and copying.

(d) For the purpose of disseminating information about the IHC Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1–25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

11:20–2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, individuals' preferences and the evolution of the marketplace towards managed care.

2. A committee may design or revise the standard health benefits plans, but the Board shall discuss the design and any changes thereto at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any revisions thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing pursuant to Article III of this Temporary Plan and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Interim Administrator.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended.

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

6. The Board shall consider, at least annually, whether to revise the standard health benefits plans. Such consideration shall take into account comments and complaints from covered individuals, members, and producers; trends in the small employer group and large employer group markets; actions of State and Federal agencies; and actions of the New Jersey Legislature and Congress.

(b) Members shall submit to the Board, in the care of the Interim Administrator or subsequently appointed Administrator, a certification that sets forth that the standard policy and application forms will be used in accordance with the requirements of N.J.A.C. 11:20–3.2 and 4.1.

1. As a transitional measure, members may, for a period of time, use alternative policy and application forms which are in substantial compliance with the standard policy and application forms. If alternative forms are to be used, or if the member offers a standard health benefits plan through or in conjunction with a managed care network, the member shall file the forms with the Board, in the care of the Interim Administrator or subsequently appointed Administrator, along with a certification that the forms are in substantial compliance with N.J.S.A. 17B:27A–2 et seq. and N.J.A.C. 11:20. The filing shall also include an identification of the differences between the filed forms and the standard forms.

2. No member shall issue a standard or alternative health benefits plan until a full schedule of corresponding rates has been filed with the Board in accordance with N.J.A.C. 11:20–6.

3. The Interim Administrator or subsequently appointed Administrator shall forward each certification and/or policy form and application form to the Chair of the Forms Committee within five business days of its receipt and each rate filing to the Chair of the Technical Advisory Committee within five business days of its receipt. The Interim Administrator or subsequently appointed Administrator shall retain at least one copy of each certification and/or policy form and application form and each rate filing submitted on file for proper record retention.

4. The Chair of the Forms Committee shall present the Board with a list of all certifications and alternative policy and application forms filed.

5. The Forms Committee shall review all certifications and alternative policy and application forms filed. For each alternative policy and application form, the Forms Committee shall review the forms for a recommendation to the Board as to whether or not the forms are in substantial compliance with the standard health benefits plans and application forms. The following guidelines shall be used to evaluate whether alternative forms are in substantial compliance:

i. All coverage, coverage limits, and exclusions set forth in the standard forms are included;

ii. The inclusion of words, terms and descriptions not contained in the standard policy forms does not change the meaning or effect of any material aspect of the standard form;

iii. The exclusion of words, terms, and descriptions contained in the standard forms does not change the meaning or effect of any material aspect of the standard forms;

iv. The application form includes all information on the standard form, even information which applicants are required to complete at their option; and

v. The formatting of the forms allows for easy comparison with the standard forms by consumers and the Board.

6. For any alternative form which the Forms Committee finds not to be in substantial compliance based on the guidelines of (b)5 above, the Forms Committee shall contact the submitting carrier in writing advising them of the finding including details of the noted discrepancies between the alternative form submitted and the standard form. The Carrier shall be provided the opportunity to amend the filing within a 30 day period. Any amended filing shall be reviewed according to the guidelines of (b)5 above for a recommendation to the Board.

7. The Chair of the Forms Committee shall present the Board with copies of the certifications and alternative policy and application forms reviewed. For each alternative and/or amended form, the Chair of the Forms Committee shall include a recommendation that, based on the guidelines of (b)5 above, the forms are or are not in substantial compliance with the standard forms.

8. The Board shall review those certifications, policy and application forms, along with any recommendations specific thereto presented by the Forms Committee and shall determine whether such forms are in substantial compliance with the standard health benefits plans and the standard application form.

(c) The Technical Advisory Committee shall review all rates filed, and shall compile separate lists of the rates filed according to their status as follows:

1. Rate filing complete; and

2. Rate filing incomplete, with a specific request for more information recommended.

(d) The Chair of the Technical Advisory Committee shall forward the lists established pursuant to (c) above, the rate filings assigned to those lists by the Technical Advisory Committee, and the recommendations specific to those rate filings to the Chair of the Board in a timely manner.

(e) The Board shall review those rate filings assigned to the list established pursuant to (c) above, and any recommendations specific to such rate filings and shall determine whether such rate filings are complete. Upon a determination by the Board that a rate filing is incomplete, the Board shall send notice of such determination to the affected member as specified at N.J.A.C. 11:20–6 through the Interim Administrator or subsequently appointed Administrator and shall return the lists and rate filings to the Interim Administrator or subsequently appointed Administrator to be placed on file for proper record retention.

(f) Following the return of each list established by the Technical Advisory Committee pursuant to (c) above, the Interim Administrator or subsequently appointed Administrator shall forward to the Commissioner and the Public Advocate a copy of the rate filings and a statement that the rate filings have been accepted as received or that additional information has been requested. The Interim Administrator or subsequently appointed Administrator shall forward additional information received to the Technical Advisory Committee, the Commissioner and the Public Advocate as soon as it is received.

11:20–2.11 Assessment for 1992 total reimbursable net paid losses

(a) The IHC Program Board may assess members for 1992 reimbursable net paid losses as an advance interim assessment, as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A–11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the total reimbursable net paid losses, if any, for calendar year 1992 based upon the information submitted by members on or before June 28, 1993 to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report, set forth as Exhibit K in the Appendix to N.J.A.C. 11:20, completed in accordance with N.J.A.C. 11:20–8. Such a determination shall be made by the IHC Program Board on or about July 8, 1993.

1. The reimbursable net paid losses for each member reporting net paid losses in 1992 shall not exceed the lesser of $10,000,000 or 50 percent of the member's reported net paid losses.

2. No performance standards shall be applicable to any member for purposes of determining a member's reimbursable net paid losses for 1992.

3. The total reimbursable net paid losses for 1992 shall be the aggregate of the reimbursable net paid losses for all members reporting net paid losses in 1992.

(c) Every member shall be liable for a portion of the total reimbursable net paid losses for 1992 unless a member has reported a net paid loss amount that has been included by the IHC Program Board in the total reimbursable net paid losses for 1992.

1. The IHC Program Board provided notice to members in writing on July 8, 1993 of the total reimbursable net paid losses for 1992 and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for 1992.

2. No later than 90 days following the preliminary notice by the IHC Program Board of a member's preliminary liability for a portion of the total reimbursable net paid losses for 1992, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed on an interim basis against the member for its portion of the total reimbursable net paid losses for 1992.

3. The IHC Program Board shall provide notice to members in writing on or before November 1, 1993 of the first reconciliation of the assessment for 1992 reimbursable net paid losses which will include adjustments in market share and adjustments made for deferrals granted on or before October 20, 1993.

4. The IHC Program Board shall notify each member of the final reconciliation of the assessment and reimbursement for 1992 reimbursable net paid losses by invoice stating the dollar amount then due or credit, if any, against future assessments by April 1, 1994. As a result of the final reconciliation, any monies determined to be owed to or by Board, shall be calculated without provision for interest.

(d) Each member's assessment amount shall be determined by multiplying the member's adjusted market share, to be determined as described in (d)1 through 3 below, against the total reimbursable net paid losses for 1992, except that no member shall be liable for an assessment amount greater than 35 percent of the total reimbursable net paid losses for 1992.

1. The IHC Program Board shall determine each member's adjusted market share by comparing the member's net earned premium for calendar year 1992 to the net earned premium of all members excluding members with 1992 reimbursable net paid losses for calendar year 1992, as reported by each member on or before June 28, 1993 to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report, set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20–8. Should a member fail to submit a Carrier Market Share and Net Paid Loss Report as required by N.J.A.C. 11:20–8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement filed with the Department.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective adjusted market shares.

3. A member's assessment in amounts exceeding the 35 percent limit shall be apportioned to other members, based upon their respective adjusted market shares, until such other members reach the 35 percent limit or the total reimbursable net paid losses for 1992 are fully assessed, whichever occurs first.

(e) Assessment amounts are due and payable upon receipt of an invoice by a member for the assessment. Payment shall be by bank draft made payable to the Treasury—State of New Jersey, IHC Program, c/o the New Jersey

Department of Insurance, 20 W. State Street, CN–325, Trenton, N.J. 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20–11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Interim Administrator (or Administrator) shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for 1992. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for 1992, until all such available funds have been paid out, or a member's reimbursable net paid losses for 1992 have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed to members having reimbursable net paid losses in 1992, until such time as the dispute has been settled or concluded with the disputing member, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses in 1992 in accordance with (g) above, along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Interim Administrator (or Administrator) receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

(h) An assessment for the 1992 reimbursable net paid losses, as an advance interim assessment, shall be credited as an offset against any regular assessment due following the close of the following year as required by N.J.S.A. 17B:27A–11a.

11:20–2.12 Assessments for administrative expenses and organizational and operating expenses

(a) Every member shall be liable for a portion of the annual administrative expenses of the IHC Program. On or about April 15 annually the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the preceding calendar year, if any.

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final annual assessment for administrative expenses shall be reduced by any deferred assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well as to cover estimated losses.

(c) All members shall be assessed for a proportionate share of final administrative expenses for the preceding calendar year on the basis of the ratio of the member's health benefits plans net earned premiums for that calendar year to the total of all members health benefits plans net earned premiums for that calendar year. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20–8. Should a member fail to submit a Carrier Market Share and Net Paid Loss Report as required by N.J.A.C. 11:20–8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement filed with the Department.

(d) Interim assessments shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding calendar year.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall be by bank draft made payable to the Treasury—State of New Jersey, IHC Program, c/o the New Jersey Department of Insurance, 20 W. State Street, CN–325, Trenton, NJ 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (f) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (h) below pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.

(h) The Interim Administrator (or Administrator) shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed by the Board until such time as the dispute has been settled or concluded with the disputing member, or until final disposition of the request for deferral by the Commissioner, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately, along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Administrator receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

11:20–2.13 Notice of request for deferral

A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Interim Administrator (or Administrator) in order to preserve its right to any monies paid pursuant to the invoice for assessment.

11:20–2.14 Failure to pay assessments

If a member is determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

11:20–2.15 Penalties/adjustments and dispute resolutions

(a) A member seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment following the procedures established by the Board.

(b) A member which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the IHC Program Board no later than 20 days of receiving the notice of assessment following the procedures established by the Board.

(c) Concurrent with its challenge to the assessment, a member shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and submit all documentation that supports or tends to support the member's position. The member shall also advise at this time whether a hearing is requested.

(d) If a hearing is requested, within 30 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the matter does not constitute a contested case, the Board will review the challenge itself or delegate this review to an appropriate Committee to make a recommendation to the Board.

(e) If the Board determines that the nature or extent of errors or conduct by a member evidence activity for which penalties or sanctions are appropriate, the Board shall refer the matter to the Commissioner, Attorney General, and/or other appropriate enforcement agency, for appropriate action including the assessment of penalties and sanctions as provided by the Act, as well as any other penalties permitted by law. Nothing herein shall be construed to limit the authority of the Commissioner, the Attorney General or any law enforcement agency to take appropriate regulatory or enforcement action with respect to violations of law and regulations.

11:20–2.16 Indemnification

(a) The participation in the IHC Program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by the Act shall not be the basis of any legal action, criminal or civil liability, or penalty against the IHC Program, member of the Board of Directors or any member carrier either jointly or separately except as otherwise provided in the Act.

(b) The Board shall not be liable for any obligation of the IHC Program. No Director, officer or employee of the Board or the Department shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

11:20–2.17 Assessments for total reimbursable net paid losses for calendar year 1993 and thereafter

(a) The IHC Program Board may assess members for reimbursable net paid losses as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A–11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for the preceding calendar year based upon the information submitted by members no later than March 1 of each year annually to the IHC Program Board in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K in the Appendix to this chapter, completed in accordance with N.J.A.C. 11:20–8. Such a determination shall be made by the IHC Program Board on or about March 14 of each year.

1. The total reimbursable net paid losses of the preceding calendar year shall be the aggregate of the reimbursable net paid losses for all members reporting net paid losses for that calendar year.

2. Prior to receiving reimbursement for net paid losses, a member must meet the performance standards set forth at N.J.A.C. 11:20–10.

(c) The Board shall determine each member's assessment amount by multiplying the member's market share, or adjusted market share as applicable, by the total reimbursable net paid losses for the preceding calendar year, except that no member shall be liable for an assessment amount greater than 35 percent of the total reimbursable net paid losses for that calendar year.

1. The IHC Program Board shall determine each member's market share by comparing the member's net earned premium for all health benefits plans for the preceding calendar year to the net earned premium of all members for the preceding calendar year as reported by each member in the Carrier Market Share and Net Paid Loss Report, set forth as Exhibit K of the Appendix to this chapter, and completed in accordance with N.J.A.C. 11:20–8. Should a member fail to submit a Carrier Market Share and Net Paid Loss Report as required by N.J.A.C. 11:20–8, the member's market share shall be determined by the IHC Program based upon the premium set forth in the member's most recent Annual Statement filed with the Department. Members' market shares shall be adjusted in consideration of the following factors, if necessary:

i. A member that has been granted a final exemption under N.J.A.C. 11:20–9.5 shall not be assessed for any portion of the total reimbursable net paid losses.

ii. A member that has been granted a pro rata exemption under N.J.A.C. 11:20–9.5 shall be liable for an assessment determined by multiplying the total amount of reimbursable losses (program losses) for the preceding calendar year by the ratio of the member's net earned premium to the net earned premium of all members for the preceding calendar year multiplied by a fraction, the numerator of which is the difference between the minimum number of non-group persons allocated to the member by the Board and the number of non-group persons actually enrolled or insured by the member and the denominator of which is the minimum number of non-group persons allocated to the member by the Board.

2. To the extent a member's assessment exceeds the 35 percent limit, the excess amount shall be apportioned to other members, except those members that received a final or pro rata exemption or that have been granted a deferral, based upon their respective adjusted market shares until such other members reach the 35 percent limit or the total reimbursable net paid losses for the preceding calendar year are fully assessed, whichever occurs first.

3. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective adjusted market shares.

i. Members that have been granted a deferral shall remain liable to the IHC Program for the amount deferred and any additional amounts required by N.J.A.C. 11:20–11.6.

ii. Upon eventual payment of the deferred amount to the IHC Program, the members to whom the deferred amounts were reapportioned will be credited for those amounts previously apportioned to them.

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding calendar year unless the member has been granted a final exemption from assessments for the preceding calendar year by the Board in accordance with N.J.A.C. 11:20–9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about March 14 of each year, of the total reimbursable net paid losses for the preceding calendar year and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding calendar year.

2. No later than 60 days following the preliminary notice in (d)1 above, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding calendar year.

3. The IHC Program Board may, as necessary, make reconciliations of the assessment for reimbursable net paid losses which may include adjustments in market share and adjustments for deferrals granted.

4. The IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the preceding calendar year by invoice stating the dollar amount then due or credit, if any, against future assessments on or before December 1st of the current year. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

(e) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, c/o the New Jersey Department of Insurance, 20 West State Street, PO Box 325, Trenton, NJ 08625–0325.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20–11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Interim Administrator (or Administrator) shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the preceding calendar year. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that calendar year, until such available funds have been paid out, or a member's reimbursable net paid losses for the preceding calendar year have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding calendar year, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the preceding calendar year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Interim Administrator (or Administrator) receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20–3.1 Benefits provided

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A, sections III, V, VI, VII and IX;

2. Plan B, "The Basic Health Benefits Plan", Exhibit B, sections III, V, VI, VII and IX;

3. Plan C, "Individual Health Benefits Plan C," Exhibit C, sections III, V, VI, VII and IX;

4. Plan D, "Individual Health Benefits Plan D," Exhibit D, sections III, V, VI, VII and IX;

5. Plan E, "Individual Health Benefits Plan E," Exhibit E, sections III, V, VI, VII and IX; and

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F, sections III, V, and VI.

(b) In accordance with N.J.A.C. 11:20–1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans B, C, D and E as set forth in Exhibits B through E, respectively, in the Appendix.

1. Members offering Plans B, D, and E shall offer the following annual deductible options to the policyholder for each plan:

i. $500.00 per individual and $1,000 per family unit;

ii. $1,000 per individual and $2,000 per family unit;

2. Members offering Plan C shall offer the following annual deductible options to the policyholder for each plan;

i. $1,000 per individual and $2,000 per family unit; and

ii. $2,500 per individual and $5,000 per family unit.

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with either or both of the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. $1,500 per individual and $3,000 per family unit;

ii. $2,250 per individual and $4,500 per family unit;

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans B through E in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient copay, $50.00 separate emergency room copay, $25.00 maternity copay, and $15.00 for all other copays. All HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant;

1. $250.00 hospital inpatient copay, $200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 emergency room copay, $25.00 maternity copay, and $20.00 for all other copays; and/or

2. $100.00 hospital inpatient copay, $100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $50.00 emergency room copay, $25.00 maternity copay, and $10.00 for all other copays.

(d) Each of the standard health benefits plans, except the deductible options listed in (b)2 above, may be offered through or in conjunction with a managed care network, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. With respect to Plans B through E set forth in Exhibits B through E of the Appendix, and notwithstanding (d)1 above, in no event shall policyholder coinsurance be greater than 40 percent;

3. The coinsurance maximum specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits A through E in the Appendix, shall be the coinsurance maximum for the in-network and out-network benefits combined;

4. The HMO Plan copayment levels of $10.00, $15.00 and $20.00 may be substituted for deductibles applicable to one or more of the in-network benefits;

5. Notwithstanding (d)1, 2, 3 and 4 above, a carrier may submit to the Board for approval an alternative managed care delivery system which reconciles its delivery system with the standard health benefit plans; and

6. The out-network benefit level shall be the coinsurance level of the standard plan. Plan A offered through or in conjunction with a managed care network shall have an out-network hospital coinsurance amount of 20 percent and an out-network non-hospital coinsurance amount of 50 percent. Plan B offered through or in conjunction with a managed care network shall have an out-network coinsurance amount of 60 percent, Plan C shall have an out-network level of 70 percent, Plan D shall have an out-network level of 80 percent, and Plan E shall have an out-network level of 90 percent.

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges on a reasonable and customary basis as defined by the Board.

Amended by R.1995 d.531, effective October 2, 1995.
See: 27 N.J.R. 1127(a), 27 N.J.R. 3793(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Inserted new (b)2; recodified former (b)2 as (b)3; and, in (c), inserted reference to (b)2 deductible options.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Substituted Plan B for Plan A as the "The Basic Health Benefits Plan" and amended deductible and copayment amounts.
Amended by R.1998 d.26, effective January 5, 1998.
See: 29 N.J.R. 1089(a), 30 N.J.R. 237(a).
Inserted (d)6.
Administrative correction.
See: 30 N.J.R. 1318(b).

11:20–3.2 Policy forms

(a) For standard health benefit plan contracts effective on or after January 1, 1995, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F.

(b) For standard health benefit plan policies with effective dates prior to January 1, 1995, members shall convert the contracts to the respective standard policy forms set forth in the Appendix to this subchapter as Exhibits A

through F on the first 12 month contract anniversary date on or after January 1, 1995.

(c) A member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20–3.1(d) shall use the appropriate standard language set forth in the Appendix to this subchapter as Exhibit Q in conjunction with the standard policy forms set forth as Exhibits A through E.

(d) Before marketing any of the standard policy forms, a member shall file in triplicate with the Board, the Certification Form set forth in the Appendix to this subchapter as Exhibit Q. Affiliated Carriers must file separate Certification Forms. A new Certification Form must be filed any time a member makes any permitted changes in the standard health benefits forms being offered.

Repeal and New Rule, R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

11:20–3.3 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:20–3.2, members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix, incorporated herein by reference, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) Notwithstanding the requirements of N.J.A.C. 11:20–3.2, members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits A, B, C, D, E, and F of the Appendix to this Chapter through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix.

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20–4.1 Standard application form

(a) All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G of the Appendix to this chapter, except as provided in (b) below.

(b) A member may submit to the Board for approval an alternative application form that differs in format but not in content from the standard form set forth in Exhibit G of the Appendix. The member may use the alternative form when submitted unless and until disapproved by the Board.

1. The alternative application form shall be submitted along with the Certification Form set forth in the Appendix to this subchapter as Exhibit Q.

2. Alternative application forms shall be submitted in triplicate to the Board at the following address:

Executive Director
New Jersey Individual Health Coverage Program
20 West State Street, 10th Floor
PO Box 325
Trenton, NJ 08625–0325

3. The Board shall disapprove any alternative application form that is not consistent with the purpose of this chapter.

4. If any proposed alternative application form is disapproved, it may not be used with a policy form delivered or issued for delivery unless and until such disapproval is withdrawn.

5. Upon request by the member for a hearing, the Board's disapproval of an alternative application form shall be subject to review in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Administrative Correction.
See: 27 N.J.R. 1424(a).

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20–5.1 Standard Claim Form

Effective August 1, 1993, all members offering health benefits plans or other health insurance policies to individuals shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The standard claim form shall be used for all medical expenses incurred for services other than hospital inpatient services. Members shall use form UB–82 set forth as Exhibit I in the Appendix to this chapter for hospital inpatient services.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20–6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 2b(1) and 3 of the Act (N.J.S.A. 17B:–27A–3b(1) and 17B:27A–4).

11:20–6.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20–1.2, or as further defined below, unless the context clearly indicates otherwise.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

11:20–6.3 Informational filing requirements

(a) All members issuing standard health benefits plans or conversion health benefits plans on a new contract or policy form shall make, prior to issuing any standard health benefits plan or conversion benefits plan, an informational filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act;

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date, and may be developed on different rate tiers for family units (that is, different community rates for individuals, two-person families and larger families) provided that all proposed rates applicable in this State have been filed with the Board before being used;

3. A detailed actuarial memorandum, which shall include the following:

i. The rates being submitted;

ii. All information used in the development of the rates;

iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete; and

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans, conversion health benefits plans, or its community rated and modified community rated health benefits plans issued prior to June 14, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational filing, which shall include all the supporting data set forth in (a) above.

11:20–6.4 Informational filing procedures

(a) The informational filing filed by the member with the Board pursuant to N.J.A.C. 11:20–6.3(a) or (b) above shall be filed in triplicate with the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20–6.3(a) or (b) above is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Upon 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates until the Board has determined that the informational filing is complete, and written notice of that fact has been provided to the member.

(e) The Board shall, within 15 days of receipt of a member's informational rate filing and within 15 days of receipt of any material submitted or resubmitted by a member at the request of the Board in accordance with (b) above, submit copies of the filing to the Commissioner and to the Public Advocate as follows:

Commissioner of Insurance
ATTN: IHCP Rate Filings
New Jersey Department of Insurance
20 West State Street
CN–325
Trenton, New Jersey 08625–0325

Division of Rate Counsel
Department of the Public Advocate
Hughes Justice Complex
CN–850
Trenton, NJ 08625

Administrative Change.
See: 27 N.J.R. 1423(a).

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20–7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20–7.2 Definitions

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

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with N.J.A.C. 11:20–8.5(c), adjusted as required by this subchapter.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Board.

New Rule, R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

11:20–7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan in force during the preceding calendar year shall file with the Board an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter incorporated herein by reference.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans policy forms written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

Recodified from 11:20–7.2 and amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

11:20–7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form shall be completed annually by each member and shall include the following information with respect to standard health benefits plans:

1. The reporting member's name and address;

2. The member's net earned premium for the preceding calendar year;

3. A statement of the member's total losses incurred consisting of:

i. Claims paid during the preceding calendar year, regardless of the year incurred;

ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;

iii. 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;

iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;

vi. Plus a pro rata share of the reimbursable net paid loss assessment paid by the carrier pursuant to N.J.A.C. 11:20–2.17 during the preceding calendar year, determined as the member's total net paid loss assessment multiplied by the ratio resulting from dividing the member's net earned premium for standard health benefits plans for the preceding calendar year by the net earned premiums for all of the member's health benefits plans for the preceding calendar year;

4. The member's loss ratio (determined by dividing the total losses incurred by the net earned premium as determined in (a)2 above);

5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A–9 in accordance with instructions; and

6. Such other information as the Board may request.

(b) The residual reserve reported in (a) above shall consist of either:

1. A safeharbor reserve equal to 3.3 percent of the sum of (a)3i, (a)3iii and (a)3iv above; or

2. A calculated residual reserve, supported by data and assumptions demonstrating how the reserve was calculated, and an accompanying actuarial certification. A calculated residual reserve may be subject to independent audit by an actuarial firm selected by the Board. If such firm finds that the calculated residual reserve is not reasonable, supportable, or otherwise in conformance with this subchapter, the Board shall not accept the carrier's loss ratio report or approve a refund plan.

Recodified from 11:20–7.3 and amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

11:20–7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20–7.4 is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans and the amount that would have been necessary to achieve the 75 percent loss ratio.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contract holders who were covered for any period during the preceding calendar year;

2. The refund amount per contract holder shall be determined by multiplying the earned premium from each contract holder's standard health benefits plan by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier's total net earned premium from standard health benefits plans, or on the basis of a practical and equitable alternative formula proposed by the carrier for approval by the Board; and

3. Refund payments shall be made within 45 days of written approval by the Board of the refund plan.

(c) The Board may request that a carrier provide additional information or that a carrier make amendments to the refund plan. Carriers shall respond to such requests within the timeframes specified by the Board.

Recodified from 11:20–7.4 and amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

11:20–7.6 Unclaimed loss ratio refunds

(a) Any loss ratio refund issued by a carrier to a policy or contract holder pursuant to this subchapter which remains unclaimed by that policy or contract holder shall be deemed abandoned one year from the date upon which the Board approves the refund plan.

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, N.J.S.A. 46:30B–1 et seq., including, but not limited to, N.J.S.A. 46:30B–30, 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

New Rule, R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

SUBCHAPTER 8. THE IHC PROGRAM MARKET SHARE AND NET PAID LOSS REPORT

11:20–8.1 Scope and applicability

(a) This subchapter sets forth annual reporting, certification and audit requirements of market share data and losses to determine the total amount of losses which are reimbursable, and the allocation of assessments for reimbursement of those losses, as well as a basis for determining criteria to be met by carriers requesting exemption from such assessments.

(b) This subchapter shall apply to all carriers that are or become members of the New Jersey Individual Health Coverage Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member at the time that the report is to be filed.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–8.2 Filing of the market share and net paid loss report form

(a) Every member of the IHC Program shall file the report form set forth as Exhibit K in the Appendix to this chapter, on or before June 28, 1993, April 1, 1994, and annually thereafter no later than March 1. Every member shall complete Parts A, B, C and D of the report form, whether or not the member is seeking reimbursements for losses, or exemptions from assessments for losses.

(b) Affiliated carriers shall submit a combined report using the report form set forth as Exhibit K in the Appendix.

1. The combined report form shall be submitted under the name of one of the affiliated carrier's members, and shall include as attachments the separate reports of each of the members of the affiliated carrier including the separate report of the member submitting the combined report form, all as one package.

2. In lieu of a combined report for the filing due June 28, 1993, members of an affiliated carrier may submit their separate report forms with an attachment listing the other members within the affiliated carrier.

(c) Certified report forms shall be submitted by facsimile to the or mailed or delivered to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Administrative Change.
See: 27 N.J.R. 1423(a).

11:20–8.3 Net earned premium

(a) Every member shall set forth its net earned premium for the preceding calendar year ending December 31 in Part C1 of the report.

1. Net earned premium set forth in Part C1 of the report form shall include net earned premium resulting from group health benefits plans and individual health benefits plans issued, continued or renewed during the preceding calendar year, including premiums from conversion health benefits plans.

2. Net earned premium reported in Part C1 of the report form shall be based upon, if not the same as, the data set forth in the member's annual reports, as follows, adjusted to meet the definitions set forth in this subchapter as necessary:

i. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 3 less Column 4, line 23 plus line 23.2 plus line 24.6;

ii. The NAIC Fire and Casualty Blank (Yellow), State page 14 entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, line 13 plus line 15.1 through line 15.6;

iii. The NAIC HMDI Blank (White), page 6, entitled "Underwriting and Investment Exhibit," Part 1, Line 5, Column 9 less (Column 2 minus Column 3), and less reinsurance portions of (Column 5 minus Column 8);

iv. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Lines 1 plus 2 plus 4 plus 5; or

v. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

11:20–8.4 Calculation of covered non-group persons

Members shall report in Part C2 of the report form the total number of persons covered under individual community rated health benefits plans, individual modified community rated health benefits plans, conversion health benefits plans, the number of Medicaid recipients covered by the member under a contract with the State of New Jersey, and Medicare lives covered by the member under Medicare cost and risk contracts with the Federal government, and contracts covering actual HealthStart Plus recipients, as of December 31 of the preceding calendar year. For contracts issued prior to August 1, 1993, where a member's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; husband and wife = 2; parent and child(ren) = 2.8; family = 3.9. If a husband and wife category is not used, a member shall use a composite factor of 3.33 in order to reflect the husband and wife category in the family factor.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–8.5 Calculating net paid losses or gains

(a) For purposes of completing Part C3 of the report form, members shall provide data for their individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A–3b(1) or 4), for the preceding calendar year ending December 31.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) Premium earned shall be adjusted by any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plan for which the report is being made, as necessary:

1. The NAIC Life and Health Blank (Blue), State page 19 entitled "Accident and Health Insurance," Column 3 less Column 4, line 23.2 plus 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 3, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 1 plus 2; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

(c) In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member, adjusted as necessary for the individual health benefits plans for which the report is being made, with the following serving as the basis:

1. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 5, line 23.2 plus line 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 6, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Underwriting and Investment Exhibit, Part 2, Column 2, less reinsurance, adjusted to Individual, less Complementary Medicare and Group;

4. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year (Lines 20 minus 7 minus 3 minus 17) less page 31, Report No. 1, Part B, (Column 3, line 2 through 6 less Column 4, lines 2 through 6); or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, (Lines 16 plus 20) less Report No. 1, Part B, ((Column 3, Lines 2 plus 3) minus (Column 4, Lines 2 plus 3)).

(d) Expenses shall reflect current expense items only and shall exclude prior period adjustments as well as excluding surplus adjustments and Federal and State income taxes. Expenses shall include premium taxes and commissions. Expenses shall be reported consistent with the following bases, as appropriate to the member, adjusted for New Jersey, and adjusted for the individual health benefits plans for which the report is being made, as necessary, but in no instance shall expenses exceed 25 percent of premium earned:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, lines 20, 22, and 23 (less State income taxes);

2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part III, Columns 5, 6, 12, 13, 14, 15, line 15;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 5, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 26; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 27.

(e) Blue Cross and Blue Shield of New Jersey, Inc. shall report the amount of subsidy receivable based upon discount factors approved by the Hospital Rate Setting Commission for its individual line of business in 1992, not including the "fast payor" discount factor included in the 1992 hospital payor differential.

(f) Net investment income shall be calculated in accordance with statutory reporting requirements and allocated on a consistent basis to individual lines, adjusted for State and reinsurance as necessary. The net investment income shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plans for which the report is being made as necessary:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, line 4;

2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part II, Column 18, line 15;

3. The NAIC HMDI Blank (White), page 4, Column 1, line 7, adjust for individual lines, reinsurance and Complementary Medicare;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 6; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 5.

11:20–8.6 Certifications

(a) The Chief Financial Officer, or other duly authorized officer of the member, shall certify that all market share and net paid loss reports filed with the IHC Board are accurate, complete and conform with the requirements of this subchapter. The person certifying the combined market share and net paid loss report of an affiliated carrier shall be the same person certifying the separate market share and net paid loss report of the member submitting the combined market share and net paid loss report for the affiliated carrier. Every duly authorized officer who certifies a separate or combined market share and net paid loss report shall be responsible for errors contained therein.

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before April 1, 1994 and annually thereafter on or before March 1, that:

1. The administrative expenses reported therein are allocated on a basis consistent with previous market share and net paid loss reports and annual statements or other corporate reports of the member required to be filed with the Commissioner pursuant to law or regulations or, if changed, the changes have been outlined in detail including the impact and reason for the change; and

2. The net investment income reported therein has been allocated on a basis consistent with previous market share and net paid loss reports and annual statements or other corporate reports of the member required to be filed with the Commissioner pursuant to law or regulations or, if changed, the changes have been outlined in detail including the impact and reason for the change.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Case Notes

Health insurer became member of Individual Health Coverage Program subject to assessment for share of program losses upon receiving certificate of authority to operate as health maintenance organization (HMO) in state, regardless of status of its application for approval as federally qualified HMO. Matter of Individual Health Coverage Program Final Administrative Orders Nos. 96–01 and 96–22, 302 N.J.Super. 360, 695 A.2d 371 (N.J.Super.A.D. 1997).

11:20–8.7 Penalties for failure to file market share and net paid loss report

(a) Failure to file in a timely manner market share and net paid loss reports and certifications required by this subchapter shall result in:

1. The denial of a member's application for exemption from assessments for reimbursable losses; and

2. The Board's using the premium set forth in the member's most recent Annual Statement filed with the Department as the premium base to calculate that member's market share allocation of assessments for reimbursement of losses.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–8.8 Audits

(a) A member shall, upon written request of the IHC Program Board, provide additional information that the IHC Program Board may require to substantiate that the member has met the requirements in N.J.A.C. 11:20–8.6(b).

(b) The IHC Program Board shall review, and may audit, a member's reimbursable losses reported in the member's market share and net paid loss report. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the member being audited shall share equally the cost of an independent audit.

(c) The IHC Program Board shall adjust a member's reported net paid losses, for purposes of determining reimbursement for losses for the preceding calendar year, for the member's failure to meet the certification requirements of this subchapter or as a result of the findings of an independent audit conducted pursuant to (b) above.

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–8.9 Hearings

Any member that is denied reimbursement of losses, in whole or in part, on the grounds that the member has failed to meet the certification and reporting requirements of this subchapter, or as a result of the IHC Program Board's review of an independent audit of the member's reported net paid losses, may request a hearing within 20 days of the date that the IHC Program Board notifies the member of its final determination, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons that the Board's action should be reconsidered.

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

SUBCHAPTER 9. EXEMPTIONS

11:20–9.1 Purpose

The purpose of this subchapter is to set forth the procedures for obtaining conditional exemptions, reporting and certifying the number of non-group persons, and the standards for granting final or pro rata exemptions from assessments for reimbursement of losses in accordance with N.J.S.A. 17B:27A–12.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–9.2 Filing for an exemption from assessments for reimbursements

(a) A member seeking to be exempted from the obligation to pay assessments for reimbursement of losses shall submit a written request for such exemption to the Board. A written request for an exemption shall be submitted annually on or before May 1, except that in 1993, written request for exemptions shall be submitted to the Board on or before August 1, 1993 and in 1994, written request for exemptions shall be submitted to the Board on or before June 1, 1994. No exemptions from assessments for 1992 losses will be granted. Written requests shall be submitted to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. To enroll or insure the minimum number of non-group persons necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20–93;

2. To enroll or insure the minimum number of non-group persons under:

i. Standard health benefit plans;

ii. Health benefits plans designed to meet the requirements for enrollment of Medicaid recipients and HealthStart Plus recipients, if such health benefits are offered and required to provide coverage not in compliance with the standard health benefits plans, pursuant to N.J.S.A. 30:4D–7b or 7c, or N.J.S.A. 26:2H–18.47, and any rules and regulations promulgated thereunder; and

iii. Medicare cost and risk contracts with the Federal government, with respect to Medicare recipients, if offered; and

3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans in that calendar year for which an exemption is sought by the member.

(c) Within 30 days of receipt of the member's written request for an exemption, the Board shall grant the member a conditional exemption, or deny the member's request for an exemption in writing, specifying the reasons for the denial. If the member's written request for an exemption is neither approved nor disapproved within 30 days of its receipt by the Board, the written request shall be deemed to be conditionally approved.

(d) Approval of a member's written request for an exemption is conditioned upon the following:

1. Compliance by the member with N.J.A.C. 11:20–8 and this subchapter;

2. Compliance by the member with (b) above, as appropriate.

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, request a hearing, to be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons why the Board's decision should be reconsidered.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Administrative Change.

See: 27 N.J.R. 1423(a).

11:20–9.3 Minimum enrollment share

(a) On or about July 8, 1993, on or about May 1, 1994, and annually thereafter on or before April 1, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that calendar year which the member must agree to cover in that calendar year for purposes of obtaining an exemption from assessments for reimbursements for losses incurred in that calendar year.

(b) The IHC Program Board's determination of minimum enrollment shares shall be based upon information provided by members in accordance with N.J.A.C. 11:20–8 and this subchapter.

(c) The minimum number of non-group persons shall be calculated as the total number of community rated and modified community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid and HealthStart Plus lives of all carriers subject to the Act as of the end of the preceding calendar year multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for the preceding calendar year including those carriers exempt from assessment.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons:

1. Standard health benefits plans;

2. Conversion policies issued pursuant to the Act;

3. Contracts covering HealthStart Plus recipients; and

4. Medicare cost and risk contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's total number of non-group persons.

(b) If the member is a Federally-qualified HMO that is tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the Federal Internal Revenue Code of 1986, 26 U.S.C. 501, the member may count persons covered under (a)1 through (a)4 above, except that in determining whether the member meets its minimum number of non-group persons, the total may include no more than one-third Medicare recipients and one-third Medicaid recipients.

11:20–9.5 Procedures for granting or denying exemptions

(a) A member granted a conditional exemption shall be granted a final exemption from assessments for reimbursements for losses accruing for the calendar year in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to (b) below evidences the following:

1. By the end of calendar year 1993, the member has enrolled or insured at least 40 percent of the minimum number of non-group persons allocated to it by the Board;

2. By the end of calendar year 1994, the member has enrolled or insured at least 75 percent of the minimum number of non-group persons allocated to it by the Board; and

3. By the end of calendar year 1995 and thereafter in each calendar year, the member has enrolled or insured 100 percent of the minimum number of non-group persons allocated to it by the Board.

(b) Members seeking final or pro rata exemptions shall report to the Board, on or before April 1, 1994, and annually thereafter on or before March 1, the number of non-group persons covered by that member as of December 31 of the preceding calendar year, so that the Board can determine whether the member has satisfied its minimum enrollment share. The member shall report separately the number of non-group persons in each category of non-group persons enumerated in N.J.A.C. 11:20–9.4. The Chief Financial Officer, or other duly authorized officer of the member, shall certify that the covered non-group persons reported therein:

1. Were counted in accordance with N.J.A.C. 11:20–9.4;

2. If covered by standard health benefits plans and conversion health benefits plans, were enrolled on an open enrolled and community rated basis;

3. Were actual covered lives and not estimations of covered lives based on conversion factors applied to contracts or other approximation methods;

4. Were enrolled as of December 31 of the preceding calendar year; and

5. Do not include persons whose premium due is more than 30 days overdue.

(c) A member shall, upon written request of the IHC Program Board, provide additional information that the IHC Program Board may require to substantiate that the member has met the requirements in (b) above.

(d) The IHC Program Board shall review, and may audit, a member's non-group persons reported pursuant to (b) above. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the

member being audited shall share equally the cost of an independent audit.

(e) The IHC Program Board shall adjust a member's reported non-group persons, for purposes of determining whether the member should receive an exemption or pro rata exemption from assessment for reimbursable losses, for the member's failure to meet the certification requirements of (b) above or as a result of the findings of an independent audit conducted pursuant to (d) above.

(f) Members receiving final exemptions from the Board shall not be liable for any portion of any assessments for reimbursements for losses for the calendar year for which the final exemption is granted. The Board shall determine, in writing, whether the member is granted a final exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

1. A member granted a conditional exemption that enrolls or insures fewer than the minimum number of non-group persons allocated to it by the Board shall be liable for a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member, subject to a demonstration by the member in writing to the Board that the member has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board.

2. If the Board finds that the member has not made a good faith effort to enroll or insure its minimum number of non-group persons, the Board shall not grant a pro rata exemption to the member. The Board shall notify the member in writing as to its reasons for not granting the member a pro rata exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

(g) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, request a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons that the Board's action should be reconsidered.

(h) A member requesting a hearing by the Board shall remain liable for the full amount of any assessments for reimbursements for losses issued to it by the Board, until and unless the Board makes a finding that the member is liable for a pro rata assessment only, including any interest that may accrue.

(i) Members granted final exemptions or pro rata exemptions shall not be liable for any amount of reimbursements for losses which remain unreimbursed in accordance with N.J.S.A. 17B:27A–12e.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–9.6 Good Faith Marketing Report

(a) In order for the Board to determine whether a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20–9.5(f)2, members that have received conditional exemptions from assessments for reimbursable losses and have enrolled less than 50 percent of the minimum number of non-group persons determined by the Board shall submit to the Board a marketing report on or before July 1 of the year following the calendar year to which the conditional exemption applies containing the following information pertaining to advertising, marketing, and promotion efforts in direct support of sales of standard health benefits plans during the calendar year to which the conditional exemption applies:

1. With respect to print media, the names of newspapers, magazines or other print media, including billboards, in which advertising was placed; the number of times an advertisement appeared in each; the dates those advertisements appeared; the size of the advertisements in each; copies of such advertisements; the total cost of print media advertising; and the number of non-group persons enrolled as a result of such efforts, if available;

2. With respect to broadcast media, the names of television stations, radio stations, or cable television franchises over which commercial advertising appeared; the number of times a commercial advertisement was broadcast or played, the time of day and the duration of each; audio or video tapes of such commercial advertisements; the total cost of such broadcast media advertising; and the number of non-group persons enrolled as a result of such efforts, if available;

3. With respect to direct marketing by mail or telephone, the number of mailings distributed or calls placed; the approximate dates of the mailings or telephone calls; the geographic areas to which the mailings or calls were addressed; copies of the mailings or scripts of the telephone calls; the total cost of direct marketing through mail or telephone solicitation; and the number of non-group persons enrolled as a result of such efforts, if available;

4. With respect to sales through producers licensed by the State of New Jersey, details of efforts to recruit and educate producers to sell standard health benefits plans; the number of producers through whom such sales were made; the total cost of commissions or other incentives paid to producers for sales of standard health benefits plans; and the number of non-group persons enrolled as a result of such efforts, if available;

5. With respect to other forms of marketing or promotion of standard health benefits plans, describe the methods or media used; the frequency of use; the total cost of such efforts; and the number of non-group persons enrolled as a result of such efforts, if available.

(b) Carriers required to submit the marketing report described in (a) above shall send it to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

(c) The Board will review the marketing reports submitted and determine that a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20–9.5(f)2 if the carrier has demonstrated that it has either:

1. Undertaken a significant media advertising or other marketing campaign, in proportion to its minimum enrollment share, in direct support of sales of standard health benefits plans; or

2. Undertaken significant efforts, in proportion to its minimum enrollment share, to educate licensed insurance producers about its standard health benefits plans and has offered to pay competitive commission schedules for sales of such plans and competitive rates.

(d) A member's failure to file the marketing report described in (a) may result in the Board's denial of a final exemption from assessment for reimbursable losses.

New Rule, R.1994 d.352, effective June 17, 1994.
See: 26 N.J.R. 2737(a), 26 N.J.R. 2904(a).
Amended by R.1994 d.509, effective September 15, 1994.
See: 26 N.J.R. 3809(a), 26 N.J.R. 4193(a).
Administrative Change.
See: 27 N.J.R. 1423(a).

SUBCHAPTER 10. PERFORMANCE STANDARDS AND REPORTING REQUIREMENTS

Source and Effective Date

R.1994 d.142, effective February 23, 1994.
See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(b).

11:20–10.1 Purpose and scope

(a) The purpose of this subchapter is to establish performance standards and reporting requirements which a member shall meet in order to receive reimbursement for losses reported pursuant to N.J.A.C. 11:20–8 for calendar year 1993 and thereafter.

(b) This subchapter applies to all members that seek reimbursement for losses.

11:20–10.2 Definitions

Words and terms used in this subchapter shall have the meanings defined in N.J.S.A. 17B:27A–2 and N.J.A.C. 11:20–1.

11:20–10.3 Filing requirements and Board review

(a) Every member seeking reimbursement for losses, in accordance with N.J.A.C. 11:20–2.8 and 2.11, shall provide a Performance Report to the IHC Program Board, annually no later than April 1, which contains the following:

1. A statement certified by the Chief Executive Officer of the member that:

i. The member's performance for the preceding calendar year reflected good faith efforts to apply sound risk management principles in an efficient manner; and

ii. If applicable, the member applied the same individual case management and claims handling techniques and other methods of operation to its group and non-group business, for the same delivery system, as provided in its health benefits plan policies and contracts; and

2. An audit statement of an annual audit of the member's accounts receivable, premium billing operations, and claims eligibility systems, performed by an independent auditor at the member's expense.

(b) A member shall demonstrate to the IHC Program Board's satisfaction that the member has met the performance standards set forth in (a)1 above.

(c) The IHC Program Board shall review and may audit a member's Performance Report. The IHC Program Board shall choose and direct the independent auditor. The costs of an independent audit of a member's Performance Report shall be shared equally by the IHC Program Board and the member being audited.

(d) The IHC Program Board shall adjust a member's reported net paid losses to account for the member's failure to meet performance standards and filing requirements.

11:20–10.4 Hearings

Any member that is denied reimbursement for losses, in whole or in part, on the grounds that the member has failed to meet the performance standards and filing requirements of this subchapter, may request a hearing within 20 days of the date that the IHC Program Board notifies the member of its final determination, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons that the Board's action should be reconsidered.

11:20–10.5 Penalties

A member's failure to meet the performance standards and filing requirements set forth in this subchapter may result in the imposition of penalties provided by law.

SUBCHAPTER 11. RELIEF FROM OBLIGATIONS IMPOSED BY THE INDIVIDUAL HEALTH INSURANCE REFORM ACT

Authority

N.J.S.A. 17:1–8, 17:1–8.1, 17:1C–6(e), and 17B:27A–2 et seq.

Source and Effective Date

R.1993 d.654, effective December 20, 1993.
See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

11:20–11.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A–12 or 17B:27A–13 (including assessments for IHC Program losses and administrative expenses), or to offer coverage or accept applications to provide a standard health benefits plan to eligible persons, pursuant to N.J.S.A. 17B:27A–8.

(b) This subchapter applies to all members of the IHC Program.

11:20–11.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–2 and N.J.A.C. 11:20–1, when used in this subchapter, shall have the meanings as defined therein, 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.

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A–2 et seq.

"Financially impaired" means a member which, after December 20, 1993, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations imposed pursuant to N.J.S.A. 17B:27A–12 and 17B:27A–13, or a waiver of obligations pursuant to N.J.S.A. 17B:27A–8, as applicable.

11:20–11.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A–12a(3) or 17B:27A–13 shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:20–11.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:20–11.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

(e) If a request fails to materially comply with the filing format and information requirements set forth in N.J.A.C. 11:20–11.4 and this section, the Department shall notify the member that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(s). If the member intends to pursue its request, the member shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in this section within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the member's request being denied.

(f) All requests for relief or other information required pursuant to this subchapter shall be filed with the Department at the following address:

IHC Program
Request for Relief
New Jersey Department of Insurance
Division of Financial Solvency
20 West State Street
CN–325
Trenton, NJ 08625

11:20–11.4 Informational filing requirements

(a) When requesting relief from obligations imposed pursuant to N.J.S.A. 17B:27A–4, 17B:27A–12 or 17B:27A–13, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:

   i. The name of the applicant;

ii. The form of relief and, if a deferral of less than the full amount, specific amount/percentage of relief which the applicant is requesting;

iii. A statement of facts relied upon as the basis under which relief is sought, including the specific factor(s) upon which the Commissioner may find that the member is or would be placed in a financially impaired position as set forth in N.J.A.C. 11:2–27.3(a)1 to 29; and

iv. 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;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

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

4. A statement addressing whether the applicant 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 applicant is a member of a holding company system, the following shall be provided:

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 applicant; and

iii. A copy of the registration statement filed pursuant to N.J.S.A. 17:27A–3 and the applicant'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 applicant 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 applicant;

i. If the applicant is a health maintenance organization, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (a)6 above;

7. A report signed by the attesting actuary referred in (a)6 above, 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 applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

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. Except for requests for relief from the obligation to pay assessments pursuant to N.J.S.A. 17B:27A–13, three year financial projections beginning with the calendar year of the date of the filing assuming relief is granted and assuming relief is denied. The projections shall include, in summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the applicant in making the projections. The projections shall include results for the applicant's operations worldwide by line of business and for the applicant's operations in New Jersey only for individual health benefits plans issued pursuant to N.J.S.A. 17B:27A–2 et seq. The projections shall assume the same rate of assessment as in the first year for the subsequent years, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

i. For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the insurer;

ii. For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the insurer;

iii. For health service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the health service corporation; and

iv. 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 non-refundable filing fee of $1,000, unless the applicant 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 applicant's state of domicile; and

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

(b) An applicant asserting that the Department's review of its request be evaluated on a particular 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 particular basis is appropriate to that applicant, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I _____ certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:20–11 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 applicant."

11:20–11.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter 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, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

1. N.J.A.C. 11:20–11.4(a)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:20–11.4(a)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:20–11.4(a)3—most recent financial examination report;

4. N.J.A.C. 11:20–11.4(a)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;

5. N.J.A.C. 11:20–11.4(a)8—annual statement filed immediately preceding date of filing;

6. N.J.A.C. 11:20–11.4(a)12—non–refundable filing fee; and

7. N.J.A.C. 11:20–11.4(a)13—additional information required by the Commissioner to evaluate a particular filing.

11:20–11.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A–8 or 17B:27A–12a(3), as applicable, that the member is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A. 17B:27A–12a(3) or 17B:27A–13, the member shall remain liable to the IHC Program for the amount deferred.

(b) The Commissioner shall find that a member is or would be financially impaired if:

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

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

3. The Commissioner finds that fulfillment of the obligation(s) from which relief is sought would place the member in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2–27.

(c) Any waiver or deferral from a particular obligation granted by the Commissioner pursuant to this subchapter shall be for a specified period as set forth in the notice granting the request, but shall not exceed 12 months from the date of the notice. Any member seeking to continue a waiver or deferral shall file a separate request for relief in accordance with this subchapter no later than 45 days prior to the expiration of the waiver or deferral period set forth in the original notification granting the request. Such a request shall also include a detailed explanation of all actions the applicant has taken and intends to take to cure the financial impairment. Failure to file a properly completed request for relief within the time prescribed shall result in the expiration of the waiver or deferral at the expiration of the period set forth in the original notification granting the request. Nothing herein shall be construed as limiting or prohibiting any member from applying for relief at any time in accordance with this subchapter.

(d) If the Commissioner grants a request for a deferral of payment of an assessment, the terms of the deferral shall include the requirement that the member shall pay to the Board an additional amount representing the loss to the Board of the time value of the assessment for the period of the deferral.

1. In calculating the additional amount to be paid, the member shall use the annual interest rate on one-year U.S. Treasury bills as of the date the assessment was due and payable.

2. In calculating the additional amount to be paid, the period of deferral shall begin on the date that payment of the assessment was due and payable and end on the date the amount deferred is paid to the Board.

3. The payment of the additional amount set forth in (d) above shall be in lieu of payment by the member of any interest or penalty on the amount deferred, which otherwise may be required under any other rule.

4. The requirement to pay an additional amount as provided in (d) above shall not apply when the reason for granting the deferral is that the member is in rehabilitation or conservation.

11:20–11.7 Hearings

(a) If the Commissioner denies a member's request for relief made pursuant to this subchapter, or if the member objects to the terms of the relief granted, the member 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 concise statement describing the basis for which the member believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the member 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. 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.

ii. 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 facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

11:20–11.8 Notice to the IHC Program

Members requesting relief pursuant to this subchapter shall concurrently provide notice of all such requests to the IHC Program through the Interim Administrator or Administrator, as appropriate. Members shall also provide notice to the IHC Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition.

11:20–11.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member health maintenance organization (HMO) asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it does not have the capacity to enroll additional members, pursuant to N.J.S.A. 17B:27A–8a, shall file the following information with the Commissioner:

1. A cover letter stating:

i. The name of the member HMO;

ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it does not have the capacity in its facilities to enroll additional members, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member;

iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A–8a; and

iv. A certification signed by the president or duly authorized officer that the member shall not offer coverage to or accept any new group members, pursuant to N.J.S.A. 17B:27A–8a. Individual additions to existing groups shall not be considered new group members.

(b) The member shall concurrently file the information required pursuant to (a) above with the IHC Program.

11:20–11.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32–31 et seq.

11:20–11.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the Board pursuant to N.J.S.A. 17B:27A–2 et seq. and the IHC Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

SUBCHAPTER 12. ELIGIBILITY FOR AND REPLACEMENT OF STANDARD HEALTH BENEFITS PLANS

Authority

N.J.S.A. 17B:27A–16.

Source and Effective Date

R.1994 d.54, effective December 30, 1993.
See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

11:20–12.1 Purpose and scope

(a) This subchapter establishes the standards for determining who may be covered by a standard health benefits plan, as defined at N.J.A.C. 11:20–1.2.

(b) This subchapter sets forth the standards for obtaining a standard health benefits plan by persons covered by, or eligible for, group health benefits plans and persons covered by individual health benefits plans.

(c) This subchapter shall apply to persons applying for coverage by standard health benefits plans in New Jersey, all carriers which are members of the program, insurance producers selling standard health benefits plans, and employers offering group health benefits plans to their employees.

11:20–12.2 Definitions

For the purposes of this subchapter, words and terms used herein shall have the meanings set forth by the Act, or as may be more specifically defined at N.J.A.C. 11:20–1.2, unless otherwise defined below, or the context clearly indicates otherwise.

"Eligible to participate in a group health benefits plan" means, with respect to a group health benefits plan offered by an employer to an employee and the employee's dependents, the employee works at least the minimum number of hours required for participation in the group health benefits plan, the employee has been employed for at least the minimum period required by the employer and the employee, and the employee's qualified dependents have satisfied all other lawful standards for participation in the group health benefits plan. With respect to a group health benefits plan under an HMO contract only, a person who resides outside of the HMO's service area shall not be considered to be "eligible to participate in a group health benefits plan."

"General services" means a range of services or treatments which result in:

1. Hospital charges; and
2. Medical-surgical charges.

"Group health benefits plan" means a health benefits plan, as that term is defined at N.J.A.C. 11:20–1.2, for groups of two or more persons, except that "group health benefits plan" shall also include any self-funded health benefits plan for groups of two or more persons.

"Hospital charges" means charges for care, including room and board received in or at a hospital or other facility licensed by the state in which it is located which provides mainly for the care and treatment of sick or injured persons, but does not include facilities which mainly provide convalescent or custodial care, or government hospitals which mainly provide care to military or ex-military personnel.

"Medical-surgical charges" means charges for diagnostic care and treatment rendered by a licensed health care provider acting within the scope of his or her licensure whether or not rendered in a hospital, but which, if rendered in a hospital, would not be reflected in the hospital charge.

"Open enrollment period" means the period from October 1 through October 31, beginning in 1994 and annually thereafter. The effective date for coverage elections made during the "open enrollment period" shall be January 1 of the following year.

"Standard health benefits plan" means a health benefits plan, including riders, if any, adopted by the IHC Program Board.

11:20–12.3 Eligibility for coverage under a standard health benefits plan

(a) The policyholder of a standard health benefits plan shall be a resident, as defined at N.J.A.C. 11:20–1.2. A carrier may require reasonable proof of residency. A dependent of the policyholder may be a nonresident, but may not reside outside of the United States.

(b) A person shall not be covered by a standard health benefits plan, as the policyholder or a dependent, if the person is eligible for Medicare or a group health benefits plan, except as provided in N.J.A.C. 11:20–12.4, or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20–12.5(a).

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
In (b), deleted reference to persons eligible for Medicaid.

11:20–12.4 Replacement of a group health benefits plan with a standard health benefits plan

(a) A person who is a participant, or is eligible to participate, in a group health benefits plan that does not cover general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan.

(b) A person who is a participant, or is eligible to participate, in a group health benefits plan that covers general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement or lower deductible and policyholder coinsurance requirement than the group health benefits plan.

1. A standard health benefits plan shall be considered to have a higher deductible and policyholder coinsurance requirement than a group health benefits plan if the deductible is more than $100.00 higher and the policyholder coinsurance requirement is at least 10 percent higher than the group health benefits plan.

2. A standard health benefits plan shall be considered to have a lower deductible and policyholder coinsurance requirement than a group health benefits plan if the deductible is more than $100.00 lower and the policyholder coinsurance requirement is at least 10 percent lower than the group health benefits plan.

(c) With respect to coverage under an HMO contract, the following apply, notwithstanding (a) and (b) above:

1. A person who participates, or is eligible to participate, only in a group health benefits plan under an HMO contract may choose, only during the open enrollment period, to be covered under any standard health benefits plan, except the standard HMO benefit plan.

2. A person who participates, or is eligible to participate, only in a group health benefits plan under a non-HMO contract may choose, only during the open enrollment period, to be covered by the HMO standard health benefits plan.

(d) A carrier making determinations under (b) above with respect to a person who participates, or is eligible to participate, in more than one group health benefits plan, shall decide which group health benefits plan to compare with a standard health benefits plan, as follows:

1. If a person is seeking to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement than the group health benefits plan, the carrier shall compare the group health benefits plan with the higher, or highest, deductible and policyholder coinsurance requirement.

2. If a person is seeking to be covered by a standard health benefits plan with a lower deductible and policyholder coinsurance requirement than the group health benefits plan, the carrier shall compare the group health benefits plan with the lower, or lowest, deductible and policyholder coinsurance requirement.

(e) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above shall not consider any separately applicable deductible and policyholder coinsurance requirements for specified covered services.

(f) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above, with respect to a health benefits plan delivered under a selective contracting arrangement, shall use the in-network benefit as a basis for comparison.

(g) A carrier determining whether a group health benefits plan covers general services, according to (a) and (b) above, shall not consider any limits, coinsurance, copayment or deductible requirements which may apply to a specific type of general service, (or a covered service within a type of general service) separately from the other general services (or covered services) under either the group health benefits plan or the standard health benefits plan.

(h) Notwithstanding (a), (b) and (c) above, a carrier shall not offer a person coverage by a standard health benefits plan unless:

1. The person is required to pay a portion of the premium for coverage by the group health benefits plan in which the person participates, or is eligible to participate; and

2. The person's coverage by a group health benefits plan has been terminated or will terminate no later than 30 days after the effective date of the standard health benefits plan, except as extension of benefits provisions under the group health benefits plan or by law may be applicable.

(i) A person who is eligible only for continuation of coverage under an employer's group health benefits plan required by State or Federal law, including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and amendments thereto, may choose to be covered by any standard health benefits plan in lieu of continuing to participate in the group health benefits plan.

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
In (c)1, deleted "plan E with a $150.00 cash deductible or" following "health benefits plan, except".

11:20–12.5 Selection of a standard health benefits plan by a person covered by an individual health benefits plan

(a) A person who is covered by an individual health benefits plan other than one of the standard health benefits plans issued pursuant to this chapter may choose at any time, to replace that health benefits plan with any standard health benefits plan. A carrier shall not offer a person coverage by a standard health benefits plan unless the person's coverage by the individual health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan. As long as the covered person notifies the carrier that

issued the prior individual health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate a prior individual health benefits plan as required above, the standard health benefits plan that was intended to replace it shall be of no force and effect.

(b) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 30 days may choose, at any time, to be covered by a standard health benefits plan with the same or higher deductible and the same or higher policyholder coinsurance requirement than the standard health benefits plan being replaced, except that a person who is covered by standard health benefits plan A may choose, only during the open enrollment period, to be covered by any other standard health benefits plan. A carrier shall not offer a person coverage by a standard health benefits plan unless the coverage by the standard health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan. As long as the covered person notifies the carrier that issued the prior standard health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate the prior standard health benefits plan as required above, the prior standard health benefits plan shall nevertheless be of no force and effect as of the effective date of the new standard health benefits plan. The person shall return any benefit payments to the prior carrier and the prior carrier shall refund premiums paid for the period beginning with the effective date of the new standard health benefits plan.

(c) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 30 days may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a lower deductible or lower policyholder coinsurance requirement than the standard health benefits plans being replaced.

(d) The following rules apply to the HMO standard health benefits plan, notwithstanding (a), (b) and (c) above:

1. A person covered by standard health benefits plan E with a $150.00 deductible may replace that coverage, at any time, with coverage under an HMO standard health benefits plan.

2. A person covered by the HMO standard health benefits plan may replace that coverage, at any time, with coverage by an HMO standard health benefits plan with the same or higher copayment options than the HMO standard health benefits plan being replaced.

3. A person covered by standard health benefits plans A, B, C, or D, or plan E with a deductible of $500.00, $1,000, $1,500, $2,250 or $2,500 may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan.

4. A person covered by an HMO standard health benefits plan may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan with a lower copayment option than the HMO standard health benefits plan being replaced.

(e) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above shall not consider any separately applicable deductible or policyholder coinsurance requirements for specific covered services.

(f) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above, with respect to individual health benefits plans delivered under selective contracting arrangements, shall use the in-network benefit as a basis for comparison.

(g) Notwithstanding (b), (c) and (d) above, a carrier shall not offer a person coverage by a standard health benefits plan unless the person's coverage by the standard health benefits plan being replace has been terminated or will terminate no later than the effective date of replacement standard health benefits plan.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Administrative Correction.
See: 27 N.J.R. 1424(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
In (a), in the second sentence, deleted "30 days after" following "will terminate no later than", inserted the third sentence, and in the last sentence, inserted "that was intended to replace it"; in (b), inserted second through sixth sentences; in (d)3, added deductible amounts of $1,500, $2,250 and $2,500; and in (g), deleted "30 days after" following "will terminate no later than".

11:20–12.6 Penalties

The Board shall promptly provide the Commissioner with any information in its possession regarding possible violations of this subchapter by covered persons, employers, carriers, and insurance producers, and request that the Commissioner pursue all fines and penalties provided by law.

SUBCHAPTER 13. CERTIFICATION OF NON-MEMBER STATUS

Source and Effective Date

R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

11:20–13.1 Purpose and scope

The purpose of this subchapter is to provide a means by which carriers and other entities may be certified as non-members of the IHC Program.

11:20–13.2 Non-member status

(a) An entity is a non-member of the IHC Program if:

1. It is not a carrier as that term is defined in N.J.A.C. 11:20–1.2;

2. It is a carrier that neither has issued nor has in force health benefits plans during the calendar year of certification; or

3. It is a carrier that is permitted by law to be certified as a non-member.

11:20–13.3 Filing of non-member certification requests

(a) A carrier or other entity that desires to be considered a non-member of the IHC Program for a given calendar year shall file with the Board a request for non-member certification by April 1, 1994, for calendar year 1993, and thereafter by March 1 following the end of the calendar year for which non-member status is sought. Such request shall be sent to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h).

(b) A carrier or other entity that submits a request for non-member certification shall include an affirmative statement, certified by a duly authorized officer, of the reasons for which non-member status is requested.

(c) A carrier or other entity that submits a request for non-member certification shall file a copy of the request with the Commissioner.

Administrative Change.
See: 27 N.J.R. 1423(a).

11:20–13.4 Decisions on filings by the Board

Within 30 days of receipt of a written request for non-member status, the Board shall grant or deny the request for non-member status in writing, specifying the reasons for the decision. If the Board does not grant or deny the written request for non-member status within 30 days of its receipt by the Board, the written request shall be deemed to be approved, except that the Board may extend the decision period for an additional 30 days by notifying a carrier or other entity, in writing, of the Board's need for additional information in order to make a determination.

11:20–13.5 Review and hearing by the Board

(a) A carrier or other entity that has been denied non-member status may request a hearing by the Board in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1 within 20 days of the date of the Board's ruling. A request for a hearing shall include a detailed written explanation of the reasons that the Board's action should be reconsidered.

(b) A carrier or other entity that requests a hearing shall be considered a member of the IHC Program until and unless the Board determines that the carrier is not a member.

SUBCHAPTERS 14 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

Authority

N.J.S.A. 17B:27A–11f and 17B:27A–16.

Source and Effective Date

R.1994 d.53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

11:20–17.1 Purpose and scope

(a) This subchapter provides for the quarterly and annual submission of enrollment status reports by all members of the IHC Program, and sets forth the procedures and format for those reports.

(b) This subchapter applies to all members of the IHC Program that issue standard health benefits plans to individuals.

11:20–17.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–2 and N.J.A.C. 11:20–1, when used in this subchapter, shall have the meanings as defined therein, 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 following meanings, unless the context clearly indicates otherwise.

"Enrollment status report" means a complete and accurate document that is prepared and filed in accordance with the requirements of this subchapter and sets forth the information in the format of Part 1 of Exhibit L for the

quarterly submission and Part 2 of Exhibit L for the annual submission in the Appendix to this chapter, which is incorporated herein by reference.

11:20–17.3 Filing requirements

(a) Every member of the IHC Program issuing standard health benefits plans shall complete and file with the Board the enrollment status reports required by this subchapter.

(b) Members shall file enrollment status reports on a quarterly basis reflecting in force subscriber contracts, in force persons insured, subscribers by rating category and subscribers by deductible and copayment options in the format of Part 1 of Exhibit L which shall reflect data as of March 31, June 30, September 30 and December 31 of each year. The first such report shall be filed reflecting data from August 1 through December 31, 1993.

(c) Members shall file enrollment status reports on an annual basis reflecting subscribers by zip code category, covered persons by age and sex category and subscribers by salary category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of each year. The first such report shall be filed reflecting data as of December 31, 1993.

(d) Members shall submit completed enrollment status reports to the Executive Director at the address listed in N.J.A.C. 11:20–2.1(h) no later than 45 days following the end of the quarter or end of the year (for annual reporting purposes.

(e) Affiliated carriers shall submit the enrollment status reports only on a combined basis. Each affiliated carrier shall be identified on the report.

(f) In lieu of submission on paper, members may submit the reports on a 5.25 inch 360 KB or 3.5 inch 1.44 MB computer disk, which provides the information in the format set forth in Parts 1 and 2 of Exhibit L, and includes instructions for the use of the program.

Administrative Change.
See: 27 N.J.R. 1423(a).

11:20–17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into Indemnity or PPO and POS delivery systems for Plans A through E, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. Subscriber contracts at the end of the period, which shall be calculated by adding the number of contracts in force at the beginning of the period to the number of contracts representing new sales and conversions during the period, and subtracting the number of contracts lapsed during the period.

i. New sales and conversion contracts shall be reported separately by employment status and replacement status.

(1) Employment status shall be separated into three categories: employed, unemployed, unknown. Employment status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you employed?" If the response is yes, then the contract should be reported as employed. If the response is no, then the contract should be reported as unemployed. If the question has not been answered, the contract should be reported as unknown.

(2) Replacement status shall be separated into three categories: previously insured, previously uninsured, and unknown. Replacement status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you replacing existing coverage?" If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously insured. If the question has not been answered, the contract shall be reported as unknown.

ii. A reinstatement shall be reported by reducing the number of contracts lapsed;

2. Persons insured at the end of the period, which shall be calculated by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

i. The number of lives insured should be reported in this section. For those members who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; husband and wife = 2; parent and child(ren) = 2.8; family = 3.9;

3. Contracts at the end of the period, which shall be reported separately by rating category, that is: single; husband and wife (or two person); parent and child(ren) and family; and

4. Contracts at the end of the period, which shall be reported separately by deductible options of $150.00 or $250.00, $500.00, $1,000 for Plans A–E or copayment options of $10.00, $15.00, $20.00 for the HMO Plan.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth as Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by Indemnity or PPO and POS delivery systems for Plans A–E, and if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. Number of contracts in force geographically, categorized by the first three digits of the zip code, as of December 31 of the previous year;

2. Number of lives insured, separated by sex and age distribution as of December 31 of the previous year beginning with 12/31/94; and

3. Number of contracts by salary categories as reported by the subscriber on the household income section of the application.

11:20–17.5 Penalties

Failure to provide the enrollment status reports within the time and in the format required by this subchapter shall result in the imposition of penalties as may be provided by law.

SUBCHAPTER 18. WITHDRAWAL OF CARRIERS FROM THE INDIVIDUAL MARKET AND WITHDRAWAL OF PLAN, PLAN OPTION, OR DEDUCTIBLE/COPAYMENT OPTION

Authority

N.J.S.A. 17B:27A–2 et seq.

Source and Effective Date

R.1998 d.339, effective July 6, 1998.
See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

11:20–18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the standard individual health benefits plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing: all standard individual health benefits plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to N.J.A.C. 11:20–3.1. This subchapter also establishes requirements for carriers in the event that the Board promulgates regulations repealing a specific plan, plan option, or deductible/copayment option.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the standard individual health benefits plan market in New Jersey, that seek to cease offering or renewing standard individual health benefits plans, and carriers that seek to cease issuing a specific standard plan, plan option, or deductible/copayment option as permitted herein, or as directed by the IHC Board.

11:20–18.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:20–1.2, unless defined below or unless the context clearly indicates otherwise:

"Cease doing business" for purposes of this subchapter means market withdraw or market withdrawal.

"Standard individual health benefits plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A–4b.

"State" means the State of New Jersey.

"Market withdraw" or "market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all standard individual health benefits plans and nonrenewal of all in force standard individual health benefits plans upon their respective anniversary dates without the carrier's offering replacement with a standard individual health benefits plan, except where such action is taken pursuant to N.J.S.A. 17B:27A–6.

"Plan option withdraw" or "plan option withdrawal" means a carrier's cessation of the issuance of a standard individual health benefits plan option, and the nonrenewal of all in force standard individual health benefits plans issued with that option upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A–6 or N.J.A.C. 11:20–18.5.

"Plan withdraw" or "plan withdrawal" means a carrier's cessation of the issuance of one of the standard individual health benefits plans, and the nonrenewal of all in force standard individual health benefits plans of that type upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A–6 or N.J.A.C. 11:20–18.5.

11:20–18.3 Carrier cancellation of standard individual health benefits plans

No carrier with in force standard individual health benefits plans shall cancel a standard individual health benefits plan, except in accordance with N.J.S.A. 17B:27A–6 or, upon the plan's anniversary date, N.J.A.C. 11:20–18.5, 18.6, or 18.7.

11:20–18.4 Cessation of offer and issuance of standard individual health benefits plans

(a) No carrier with in force standard individual health benefits plans shall cease to offer and issue all of its standard individual health benefits plans to an eligible person unless the Commissioner has determined pursuant to N.J.S.A. 17B:27A–8b and N.J.A.C. 11:20–11 that the carrier does not have the financial resources necessary to underwrite additional coverage, and it has notified:

1. The Board, in writing, at least 30 days before it intends to cease offering and issuing standard individual health benefits plans. Upon receipt of such notice, the Board shall no longer distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide; and

2. Its standard individual health benefits plan policyholders, in conjunction with each notice of an adjustment of rates provided to such policyholders following the date the carrier ceases to offer and issue such plans. The notice to policyholders shall state that:

i. The carrier intends to cease, or prior to July 6, 1998 has ceased, offering and issuing standard individual health benefits plans in New Jersey;

ii. The carrier will continue to renew the policyholder's health benefits plan at the policyholder's option; and

iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1–800–838–0935 for a free Individual Health Coverage Program Buyer's Guide.

(b) A carrier that notifies the Board under this section shall continue to renew all in force standard individual health benefits plans unless it obtains the Board's approval for market withdrawal in accordance with N.J.A.C. 11:20–18.5.

(c) A carrier that has ceased offering and issuing standard individual health benefits plans, but has not withdrawn from the market in accordance with N.J.A.C. 11:20–18.5, may resume offering and issuing standard individual health benefits plan to an eligible person after it has notified the Board, in writing, that it intends to resume offering standard individual health benefits plans. Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

(d) A carrier with in force standard individual health benefits plans that has ceased to offer and issue all of its standard individual health benefits plans pursuant to this section shall nevertheless continue to comply with all other provisions of the law.

11:20–18.5 General provisions for market withdrawal

(a) No carrier with in force standard individual health benefits plans, whether or not affiliated with other carriers doing business in the standard individual health benefits plan market in New Jersey, shall refuse to issue or refuse to renew a standard individual health benefits plan, except in accordance with N.J.S.A. 17B:27A–6, or in accordance with N.J.A.C. 11:20–18.4 or 18.6, unless the carrier receives approval from the IHC Board to withdraw all of its standard individual health benefits plans in accordance with the provisions of this subchapter.

(b) A carrier that seeks to withdraw shall file with the IHC Board an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the standard individual health benefits plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A–2 et seq. and all rules promulgated thereunder, including the minimum loss ratio and policyholder refund requirements, and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the IHC Board at the address set forth in N.J.A.C. 11:20–2.1, and shall include an original and two copies of the following information:

1. The name of the carrier seeking to withdraw;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for market withdrawal;

3. A statement, describing with specificity, the reasons for which the carrier is withdrawing from the individual market in this State;

4. A statement of the carrier's percentage market share in the standard individual health benefits plan market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

5. A statement indicating whether the carrier has filed for an exemption pursuant to N.J.A.C. 11:20–9 in the calendar year for which the application for market withdrawal application was filed;

6. A copy of the carrier's most recent loss ratio filing submitted pursuant to N.J.A.C. 11:20–7;

7. A copy of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20–17;

11:20–18.10 Other policy or contractholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in a policy or contract issued by a carrier.

APPENDIX

EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
BASIC HEALTH BENEFITS PLAN
(New Jersey BASIC Health Benefits Plan)

Policy Term. The Policy takes effect on [_____], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey BASIC Health Benefits Plan.

[Dividends are Apportioned each Year.]

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DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [__].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We 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.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE) . The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items (a)(3) and (b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include the Cash Deductible, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An Eligible Person who is insured under this Policy.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). 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. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
(a) Your:
(1) Spouse;
(2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat such a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
(3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item (a)(2) of the DEPENDENT definition and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who satisfies the requirements for a DEPENDENT according to item (a)(2) of the DEPENDENT definition and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to support himself or herself;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
(4) the Child depends on You for most of his or her support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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 provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section, 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. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:

-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

FACILITY. A place We are 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Policy, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

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. We 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. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;
b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited as a hospital by the Joint Commission;
b) approved as a Hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Out-of-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Covered Person's body and all complications arising from that damage.

INPATIENT. You, if You are 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.

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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.

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-covered Expenses.

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 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. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay) .

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
a) as a Covered Person; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

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

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or
b) the negotiated fee.]

The Board may 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. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) Any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and/or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE** - coverage under this Policy for the only one person.
(b) **FAMILY COVERAGE** - coverage under this Policy for You and Your Dependents.
(c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
(d) **HUSBAND AND WIFE COVERAGE** - coverage under this Policy for You and Your Spouse.
[(e) **CHILD(REN)COVERAGE** - Coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER** - You, if You are an Eligible Person, except as provided below.
(b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
(c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

(a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
(b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..

(c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Policy.

SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM, UNLESS OTHERWISE STATED.

FACILITY BENEFIT	30 days Inpatient Hospital care.
FACILITY COINSURANCE	20%
COINSURANCE CAP	$5,000 per Covered person; no benefit

	after 30 days
PRACTITIONER'S SERVICES COINSURANCE	50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

NOTE: The Coinsurance Amounts cannot be met with:
- Non-Covered Expenses
- The Cash Deductible
- Copayments

HOSPITAL INPATIENT COPAYMENT	
per Covered Person per day	$250
maximum Copayment per Covered Person per Period of Confinement	$1250
Maximum Copayment per Covered Person per Calendar Year	$2500
CASH DEDUCTIBLE PER CALENDAR YEAR	
for Hospital Confinement	NONE (Note: See Hospital Inpatient Copayment)
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
per Covered Person	$250
per Covered Family	$500
PREVENTIVE CARE	$100 / Covered Person, $300 / family. Primary Care Services are not subject to the Deductible and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED OR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premiums Rate Changes."]

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.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date of the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:
(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or
(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

BENEFIT DEDUCTIBLE, COPAYMENT AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once the Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Calendar Year. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Calendar Year. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Hospital Inpatient Copayment: Each time You are confined in a Hospital or Rehabilitation Center, which Rehabilitation Center confinement is not immediately preceded by an Inpatient Hospital stay, You must pay a $250 Hospital Inpatient Copayment for each day of confinement, up to a maximum of $1250 per Covered Person per Period of Confinement, up to a maximum $2500 Hospital Inpatient Copayment per Covered Person per Calendar Year.

Coinsurance Cap: This Policy limits the Facility Coinsurance amounts You must pay each Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Calendar Year exceed the individual cap, We waive Your Coinsurance for the rest of that Calendar Year for the Facility benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Calendar Year.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Calendar Year starts under this Policy, provided that there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied. *Note*: There is no Coinsurance credit from previous coverage.

Hospital Inpatient Copayment Carryover: There will be no carryover of Deductible or Coinsurance into the next Calendar Year. However, a Covered Person will receive credit for any Hospital Inpatient Copayment satisfied during a Period of Confinement immediately preceding or continuing into a new Calendar Year, provided, if this Policy is replacing previous coverage, that there has been no lapse in coverage between the previous coverage and this Policy.

Payment Limits: We limit what We pay for certain types of charges.

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE "UTILIZATION REVIEW" SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two home health care days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;

(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) 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:

1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:

•ordered by Your 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.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your 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: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) 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 Your Practitioner within 14 days after home health care starts;
(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.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill or terminally Injured under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill or terminally Injured Covered Person's death.

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

"Terminally Ill" or "Terminally Injured" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs If You are terminally Ill or terminally Injured. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. 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 Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished 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;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic.

We cover emergency room treatment only if such treatment subsequently results in Your admission to a Hospital.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These Covered Charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting 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 Us.]

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy, and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hour, as appropriate, of inpatient care will not be covered if you, in consultation with the Practitioner, determine hat a shorter length of stay is medically appropriate.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 Us are Non-Covered Charges.**

Practitioner Charges for Nonsurgical Care and Treatment: We only cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury under Preventive Care. See the "Schedule of Benefits" and "Preventive Care" sections of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover charges for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts, and the cost of prostheses following a mastectomy on one breast or both breasts..

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Chemotherapy, Radiation Therapy and Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the "Utilization Review" section of this Policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient care in a Hospital, We cover such care furnished to You in a Rehabilitation Center on the basis of two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished. We will pay for two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished, per Calendar Year. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second (or third) opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: We will cover up to $100 per Covered Person per Calendar Year, up to a maximum of $300 per family per Calendar Year, for routine physical examinations, Diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Preventive Care. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Deductible or Coinsurance.

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

These charges are not subject to the Deductible.

Therapy Services: We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But We do not cover Dialysis Treatment.

[**Transplants**: We cover Medically Necessary services and supplies 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.]

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION OR IF WE ASK YOU TO OBTAIN A SECOND OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S) OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND NEITHER OF THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1 - Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%. However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and appropriate, We will make payment as otherwise provided in this Policy.**

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy

Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2(a))
Hospice Care
Infusion Therapy

STEP 2 - Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care**, You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgment of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later)**, or as soon as reasonably possible, from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are medically necessary and appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3- Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4 - Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS CONFIRMS THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES .

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If You do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

ALTERNATE TREATMENT

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

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:
(a) They are determined, in advance, by Us 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 or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
(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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We 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, We will develop an Alternate Treatment Plan.

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

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

The 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:

•Us
•attending Practitioner
•Covered Person
•Covered Person's family, if any; and

d) estimated cost and savings.

If We, 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.

Exclusions

Alternate Treatment does not include services and supplies that We Determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE

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

Definitions

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

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

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

Covered Charges

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

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

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Alcoholism.

Ambulance - air, water, ground and rail.

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Policy, complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Dialysis treatment.

Dose Intensive Chemotherapy, except as otherwise stated in this Policy.

Durable Medical Equipment.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth, including bony impacted teeth.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury 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 by a Practitioner for surgery he or she performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

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

Mental or Nervous Conditions.

Methadone maintenance.

Nicotine Dependence Treatment except as provided for under Preventive Care.

Non-Prescription Drugs or supplies, except insulin, needles and syringes.

Nutritional counseling and related services, except as otherwise stated in this Policy..

Outpatient Prescription Drugs.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents, except as stated in this Policy.

Private-Duty Nursing.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
- eligible for payment under either federal or state programs (except Medicaid and Medicare.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- 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;
- for which You would not have been charged if You did not have health care coverage;
- for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- for which the Provider has not received a certificate of need or such other approvals as are required by law;
- furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- in an amount greater than a Reasonable and Customary charge;
- needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- provided by or in any locale outside the United States, other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
- provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
- received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
- which are specifically limited or excluded elsewhere in this Policy;
- which are not Medically Necessary and Appropriate except as otherwise stated in this Policy.; or
- which You are not legally obligated to pay.

Special medical reports not directly related to Your treatment (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, and non-human organ transplants [except as otherwise stated in this Policy].

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

-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 used to eliminate baldness.

CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a) name(s) and address(es) of patient and Policyholder;
b) Policyholder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us 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 Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Injury.

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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We 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.

The repayment agreement shall 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 provide benefits under this Policy to or on behalf of a Covered Person to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

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 Policy.

Our Right To Certain Information

In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. 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 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law) .

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or that of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

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

No change in the 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) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your 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.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends.
Termination by Request - If You want to replace this Policy with another Individual Health Benefits Plan, You must give Us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs.
Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, 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 Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS - INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, he or she may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will Determine the share, if any, of Our divisible surplus allocable to this Policy as of each Anniversary Date, if this Policy stays in force by the payment of 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 You in cash unless you ask that it be applied toward the premium due. Our sole liability is as set forth above.]

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with the requirements of that law.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan B.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN B
(New Jersey Individual Health Benefits B Plan)

Policy Term. The Policy takes effect on [_____], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan B.

[Dividends are apportioned each year.]

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DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [__].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We 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.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE) . The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and

d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An Eligible Person who is insured under this Policy.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). 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. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Policy's age limit;
3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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 provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section, 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. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:
-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

Ir. 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.

FACILITY. A place We are 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Policy, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

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. We 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. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;
b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited as a hospital by the Joint Commission;
b) approved as a Hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Out-of-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED.) All damage to a Covered Person's Body and all complications arising from that damage.

INPATIENT. You, if You are 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.

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges]

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

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

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay) .

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
a) as a Covered Person; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

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

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or
b) the negotiated fee.]

The Board may 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. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

[**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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or

c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) Any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Policy for only one person.
b) **FAMILY COVERAGE** - coverage under this Policy for You and Your Dependents.
c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Policy for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE POLICYHOLDER** - You, if You are an Eligible Person, except as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of October, for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.].
c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Policy.

[SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•Mental or Nervous Conditions and Substance Abuse	40%
•Other Covered Charges	40%
COINSURANCE CAP	After $3000/Covered Person, $6,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:
•Non-Covered Expenses
•Cash Deductibles
•Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$250, $500, $1000]
per Covered Family	[$500, $1000, $2000]
HOSPITAL INPATIENT COPAYMENT	
•per Covered person per day	$200
•maximum copayment per Covered Person per Period of Confinement	$1000
•maximum Copayment per Covered Person per Calendar Year	$2000

NOTE: The Hospital Inpatient Copayment is **in addition to** the Cash Deductible.

EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS SAMPLE PPO (without Copayment)

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
• if treatment, services or supplies are given by a Network Provider	[10%]
• if treatment, services or supplies are given by an Out-Network Provider	40%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]

HOSPITAL INPATIENT COPAYMENT	
•per Covered person per day	$200
•maximum copayment per Covered Person per Period of Confinement	$1000
•maximum Copayment per Covered Person per Calendar Year	$2000

NOTE: The Hospital Inpatient Copayment is **in addition to** the Cash Deductible.

EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.

THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premiums Rate Changes."]

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.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

b) the amount of any claims paid to You or Your Provider for Your claims 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

a) any Premium Due Date;

b) any date that the extent or nature of the risk under the Policy is changed:

- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

[PREFERRED PROVIDER ORGANIZATION PROVISIONS

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 We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (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 Provider, and he or she is free to change Providers at any time.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ Health Care Network] Provider or a non-[XYZ Health Care Network] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ Health Care Network] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] Provider. However, follow-up care or treatment by a non-[XYZ Health Care Network] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] Service Area.

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] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. 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] Provider will bill him or her directly.

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

What We pay is subject to all the terms of this Policy. You should read this Policy carefully and keep it available when consulting a Provider. See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You may contact Our [Claim Office at the number shown on Your identification card.]

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals 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 Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Calendar Year. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Hospital Inpatient Copayment: Each time You are confined in a Hospital or Rehabilitation Center, which Rehabilitation Center confinement is not immediately preceded by an Inpatient Hospital stay, You must pay a $200 Hospital Inpatient Copayment for each day of confinement, up to a maximum of $1000 per Covered Person per Period of Confinement, up to a maximum $2000 Hospital Inpatient Copayment per Covered Person per Calendar Year. **NOTE**: This Hospital Inpatient Copayment is **in addition** to the Cash Deductible. .

[Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Calendar Year exceed the individual cap, We waive Your Coinsurance 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 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.]**

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage.

Hospital Inpatient Carryover: A Covered Person will receive credit for any Hospital Inpatient Copayment satisfied during a Period of Confinement immediately preceding and continuing into a new Calendar Year provided, if this Policy is replacing previous coverage that there has been no lapse in coverage between the previous coverage and this Policy. Except as stated above, there is no carryover of a copayment from one Calendar Year into a succeeding Calendar Year. **Note**: There is never a carryover of Deductible or Coinsurance from one Calendar Year into a succeeding Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Hospital Inpatient Copayment.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily Room and Board Limits
During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:
a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
b) Therapy Services;
c) medical social work;
d) nutrition services;
e) home health aide services;
f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
g) 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:
1) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2) The services and supplies must be:
•ordered by Your 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.

But payment is subject to all of the terms of this Policy and to the following conditions:
a) Your 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:
1) ordered by Your Practitioner;
2) 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 Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your 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.

We do not pay for:
a) services furnished to family members, other than the patient; or
b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill or terminally Injured under a Hospice care program. Additionally, We cover charges for counseling

provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill or terminally Injured Covered Person's death.

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

"Terminally Ill" or "Terminally Injured" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill or terminally Injured. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies 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 Your Practitioner;
c) included in the Hospice care program; and
d) furnished 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;
d) treatment not included in the Hospice care plan; or
e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These Covered Charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting 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 Us.]

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy, and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hour, as appropriate, of inpatient care will not be covered if you, in consultation with the Practitioner, determine hat a shorter length of stay is medically appropriate.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 Us are Non-Covered Charges.**

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an accident) . All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if:

a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, 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 Policy.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Calendar Year, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are 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 do We cover orthodontic treatment.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Calendar Year. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Preventive Care. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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

These charges are not subject to the Deductible.

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 Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your body, or be needed due to a functional birth defect in a covered 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year per Covered Person for each of the following Therapy Services: Physical Therapy; Occupational Therapy; Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ) : We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Calendar Year. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: 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) Heart-Lung
g) Heart Valves
h) Pancreas
i) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
•Leukemia
•Lymphoma
•Neuroblastoma
•Subject to Our prior written 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 Us in writing are Non-Covered Expenses.]**

[j) 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;
k) 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.]

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION OR IF WE ASK YOU TO OBTAIN A SECOND OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S) OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND NEITHER OF THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1 - Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%. However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and appropriate, We will make payment as otherwise provided in this Policy.**

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2(a))
Hospice Care
Infusion Therapy

STEP 2 - Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care**, You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgment of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later)**, or as soon as reasonably possible, from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are medically necessary and appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3- Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4 - Obtaining a Third Opinion

If You obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS CONFIRMS THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES .

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If You do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

ALTERNATE TREATMENT

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

Definitions
"**ALTERNATE TREATMENT**" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Us 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 or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan
We 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, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) Us.
The 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:
•Us
•attending Practitioner
•Covered Person
•Covered Person's family, if any; and
d) estimated cost and savings.

If We, 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.

Exclusions
Alternate Treatment does not include services and supplies that We determine to be Experimental or Investigational.

[CENTERS OF EXCELLENCE

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

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

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

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

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

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

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT) , and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Policy; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose Intensive Chemotherapy, except as otherwise stated in this Policy.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth except as otherwise specifically covered.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury 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 by a Practitioner for surgery he or she performed on an Outpatient basis.

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

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators..

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre - Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents, except as stated in this Policy.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre - marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand - by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following:

a) Your beneficiary;
b) Your estate;
c) Your spouse;
d) Your Parents;
e) Your Children;
f) Your brothers and sisters; and
g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a) name(s) and address(es) of patient and Policyholder;
b) Policyholder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us 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 Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Injury.

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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We 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.

The repayment agreement shall 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 provide benefits under this Policy to or on behalf of a Covered Person to the extent such benefits services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

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 Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. 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 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law) .

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Policyholder's application, a copy of which is attached to the Policy;
c) any riders, endorsements or amendments to the Policy; and
d) the individual applications, if any, of all Covered Persons.

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT
The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.
No change in the 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) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
c) if a change is required by [Carrier], it is accepted by the Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS
No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your 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.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE
<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends.
<u>Termination by Request</u> - If You want to replace this Policy with another Individual Health Benefits Plan, You must give Us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)

e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs..

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS
This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, 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 Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND OUT -NETWORK PROVIDER REIMBURSEMENT
Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out Network Provider may be different than Our Network Provider Allowance; also, an Out Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after You file 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS
By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[PROVIDER RELATIONSHIP
We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES
If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT
For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS

We will determine the share, if any, of Our divisible surplus allocable to this Policy as of each Anniversary Date, if this Policy stays in force by the payment of 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 You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with the requirements of that law.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN C
(New Jersey Individual Health Benefits C Plan)

Policy Term. The Policy takes effect on [_____], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan C.

[Dividends are apportioned each year.]

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DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [__].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We 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.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE) . The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;

c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An Eligible Person who is insured under this Policy.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). 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. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Policy's age limit;
3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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 provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section, 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. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:
-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

FACILITY. A place We are 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Policy, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

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. We 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. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;

b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited as a hospital by the Joint Commission;
b) approved as a Hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Out-of-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED.) All damage to a Covered Person's Body and all complications arising from that damage.

INPATIENT. You, if You are 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.

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges]

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

[**OUT NETWORK PROVIDER.** A Provider which is not a Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay) .

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
a) as a Covered Person; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

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

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or
b) the negotiated fee.]

The Board may 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. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

[**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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or

c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) Any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Policy for only one person.
b) **FAMILY COVERAGE** - coverage under this Policy for You and Your Dependents.
c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Policy for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE POLICYHOLDER** - You, if You are an Eligible Person, **except** as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person, **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of October, for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY
a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..
c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Policy.

[SCHEDULE OF BENEFITS [non-MSA text]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•Mental or Nervous Conditions and Substance Abuse	30%
•Other Covered Charges -	30%
COINSURANCE CAP	After $2500/Covered Person,

$5,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:
•Non-Covered Expenses
•Cash Deductibles
•Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$250, $500, $1000 or $2500]
per Covered Family	[$500, $1000, $2000 or $5000]

EMERGENCY ROOM COPAYMENT $50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE 365 days, if preapproved.

SKILLED NURSING CARE 120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $300/Covered Person (except newborns)
Newborns: $500 for their first year of life.
Not subject to Deductible and Coinsurance

THERAPEUTIC MANIPULATIONS 30 visits/Covered Person.

THERAPY SERVICES

•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[[SCHEDULE OF BENEFITS [MSA text]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT 365 days Inpatient Hospital care.

COINSURANCE:	30%
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
[per Covered Person	[$1,500][$2,250]]
per Covered Family	[$3,000][$4,500]
OUT OF POCKET MAXIMUM	
per Covered Person	$3,000
per Covered Family	$5,500

Note: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

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REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	

•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%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

COPAYMENT

If treatment, services or supplies are given by a Network Provider	
•[Physician Visits	$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]

CASH DEDUCTIBLE PER CALENDAR YEAR

If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE

BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.

THERAPY SERVICES

•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•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%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

CASH DEDUCTIBLE PER CALENDAR YEAR

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE

BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year

•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given or referred by the PCP	[NONE]
•if treatment, services or supplies are given by non-referred Provider	30%

COINSURED CHARGE LIMIT

The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

COPAYMENT

If treatment, services or supplies are given or referred by the PCP

•Physician Visits	[$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]

CASH DEDUCTIBLE PER CALENDAR YEAR

If treatment, services or supplies are given by a non-referred Provider, or are not subject to a Copayment above

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$1000, $2500]
per Covered Family	[$2000, $5000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premiums Rate Changes."]

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.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

b) the amount of any claims paid to You or Your Provider for Your claims 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that the extent or nature of the risk under the Policy is changed:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

[PREFERRED PROVIDER ORGANIZATION PROVISIONS

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 We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (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 Provider, and he or she is free to change Providers at any time.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ Health Care Network] Provider or a non-[XYZ Health Care Network] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ Health Care Network] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] Provider. However, follow-up care or treatment by a non-[XYZ Health Care Network] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] Service Area.

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] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. 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] Provider will bill him or her directly.

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

What We pay is subject to all the terms of this Policy. You should read this Policy carefully and keep it available when consulting a Provider. See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You may contact Our [Claim Office at the number shown on Your identification card.]

[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.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
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 of Benefits 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 of benefits 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 Provider 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.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay 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 Copayment. When a Covered Person's PCP refers him or her to another [XYZ PO] Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ PO] Practitioners will prepare any necessary claim forms and submit them to Us

[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.]

[Once per Calendar Year, a female Covered Person may use the services of a [XYZ PO] gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

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]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ PO] Provider or a non-[XYZ PO] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ PO] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a [XYZ PO] Provider. However, follow-up care or treatment by a non-[XYZ PO] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ PO] Service Area.

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

Benefits
The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement. What We pay is subject to all the terms of this Policy.]

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals 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 Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [non MSA text]

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Calendar Year. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

[**Coinsurance Cap:** This Policy limits the Coinsurance amounts You must pay each Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Calendar Year exceed the individual cap, We waive Your Coinsurance 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 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.]**

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [MSA text]

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Calendar Year. Once any combination of persons in a family meets the Per Covered Family Cash Deductible shown in the "Schedule of Benefits" section of this Policy, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Calendar Year. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Out of Pocket Maximum: The Out of Pocket Maximums "Per Covered Person" and "Per Covered Family" are shown in the "Schedule of Benefits" section of this Policy. The Out of Pocket Maximums may only be satisfied with Covered Charges. In the case of single coverage, for a Covered Person, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Person must pay during each Calendar Year. Once the Per Covered Person Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family

must pay during each Calendar Year. Once the Per Covered Family Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Calendar Year.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.]

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily Room and Board Limits during a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:
a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
b) Therapy Services;
c) medical social work;
d) nutrition services;
e) home health aide services;
f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
g) 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:
1) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2) The services and supplies must be:
•ordered by Your 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.

But payment is subject to all of the terms of this Policy and to the following conditions:
a) Your 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:
1) ordered by Your Practitioner;
2) 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 Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your 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.

We do not pay for:
a) services furnished to family members, other than the patient; or
b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill or terminally Injured under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill or terminally Injured Covered Person's death.

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

"Terminally Ill" or "Terminally Injured" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill or terminally Injured. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies 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 Your Practitioner;
c) included in the Hospice care program; and
d) furnished 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;

d) treatment not included in the Hospice care plan; or
e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These Covered Charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting 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 Us.]

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy, and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hour, as appropriate, of inpatient care will not be covered if you, in consultation with the Practitioner, determine hat a shorter length of stay is medically appropriate.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 Us are Non-Covered Charges.**

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an accident) . All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if:
a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, 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 Policy.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Calendar Year, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are 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 do We cover orthodontic treatment.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Calendar Year. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Preventive Care. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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

These charges are not subject to the Deductible.

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 Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your body, or be needed due to a functional birth defect in a covered 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year per Covered Person for each of the following Therapy Services: Physical Therapy; Occupational Therapy; Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ) : We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Calendar Year. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: 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) Heart-Lung
g) Heart Valves
h) Pancreas
i) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
•Leukemia
•Lymphoma
•Neuroblastoma
•Subject to Our prior written 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 Us in writing are Non-Covered Expenses.]**

[j) 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;

k) 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.]

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION OR IF WE ASK YOU TO OBTAIN A SECOND OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S) OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND NEITHER OF THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1 - Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%. However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and appropriate, We will make payment as otherwise provided in this Policy.**

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2(a))
Hospice Care
Infusion Therapy

STEP 2 - Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care**, You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgment of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later)** , or as soon as reasonably possible, from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are medically necessary and appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3- Obtaining a Second Opinion
You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4 - Obtaining a Third Opinion
If You obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS CONFIRMS THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES .

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If You do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

ALTERNATE TREATMENT

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

Definitions
"**ALTERNATE TREATMENT**" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Us 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 or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan
We 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, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) Us.

The 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:
•Us
•attending Practitioner
•Covered Person
•Covered Person's family, if any; and
d) estimated cost and savings.

If We, 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.

Exclusions
Alternate Treatment does not include services and supplies that We determine to be Experimental or Investigational.

[CENTERS OF EXCELLENCE

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

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

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

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

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

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

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT) , and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Policy; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose Intensive Chemotherapy, except as otherwise stated in this Policy.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth except as otherwise specifically covered.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury 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 by a Practitioner for surgery he or she performed on an Outpatient basis.

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

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators..

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre - Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents, except as stated in this Policy.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre - marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand - by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following:
a) Your beneficiary;
b) Your estate;
c) Your spouse;
d) Your Parents;
e) Your Children;
f) Your brothers and sisters; and
g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:
a) name(s) and address(es) of patient and Policyholder;
b) Policyholder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us 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 Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Injury.

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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We 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.

The repayment agreement shall 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 provide benefits under this Policy to or on behalf of a Covered Person to the extent such benefits services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

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 Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. 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 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law) .

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE POLICY
The entire Policy consists of:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Policyholder's application, a copy of which is attached to the Policy;
c) any riders, endorsements or amendments to the Policy; and
d) the individual applications, if any, of all Covered Persons.

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT
The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.
No change in the 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) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
c) if a change is required by [Carrier], it is accepted by the Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS
No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your 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.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE
During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends.
Termination by Request - If You want to replace this Policy with another Individual Health Benefits Plan, You must give Us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give you at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs..

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS
This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, 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 Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND OUT NETWORK PROVIDER REIMBURSEMENT
Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out Network Provider may be different than Our Network Provider Allowance; also, an Out Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after You file 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS
By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[PROVIDER RELATIONSHIP
We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES
If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT
For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS
We will determine the share, if any, of Our divisible surplus allocable to this Policy as of each Anniversary Date, if this Policy stays in force by the payment of 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 You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

CONFORMITY WITH LAW
If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with the requirements of that law.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit C.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate option for sections III and V.
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN D
(New Jersey Individual Health Benefits D Plan)

Policy Term. The Policy takes effect on [_____], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan D.

[Dividends are apportioned each year.]

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DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [__].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We 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.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE) . The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;

c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An Eligible Person who is insured under this Policy.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). 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. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Policy's age limit;
3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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 provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section, 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. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:
-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

FACILITY. A place We are 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Policy, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

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. We 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. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;

b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited as a hospital by the Joint Commission;
b) approved as a Hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Out-of-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED.) All damage to a Covered Person's Body and all complications arising from that damage.

INPATIENT. You, if You are 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.

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges]

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

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

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay) .

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
a) as a Covered Person; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

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

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or
b) the negotiated fee.]

The Board may 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. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

[**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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or

c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) Any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Policy for only one person.
b) **FAMILY COVERAGE** - coverage under this Policy for You and Your Dependents.
c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Policy for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE POLICYHOLDER** - You, if You are an Eligible Person,, **except** as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person , **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy., **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of October, for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY

a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.].

c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Policy.

[SCHEDULE OF BENEFITS [non-MSA text]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•Mental or Nervous Conditions and Substance Abuse	25%
•Other Covered Charges -	20%
COINSURANCE CAP	After $2000/Covered Person,

$4,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:
•Non-Covered Expenses
•Cash Deductibles
•Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$250, $500, $1000]
per Covered Family	[$500, $1000, $2000]

EMERGENCY ROOM COPAYMENT $50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE 365 days, if preapproved.

SKILLED NURSING CARE 120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE

BENEFIT MAXIMUMS Up to $5,000/Calendar Year combined Inpatient and Outpatient.
Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $300/Covered Person (except newborns)
Newborns: $500 for their first year of life.
Not subject to Deductible and Coinsurance

THERAPEUTIC MANIPULATIONS 30 visits/Covered Person.

THERAPY SERVICES

•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS [MSA text]

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•Mental or Nervous Conditions and Substance Abuse	25%
•Other Covered Charges -	20%
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
[per Covered Person	[$1,500][$2,250]]
per Covered Family	[$3,000][$4,500]
OUT OF POCKET MAXIMUM	
per Covered Person	$3,000
per Covered Family	$5,500

Note: The Cash Deductible and Out of Pocket Maximum cannot be met with Non-Covered Expenses.

HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	20%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given by a Network Provider	
•[Physician Visits	$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
EMERGENCY ROOM COPAYMENT admission within 24 hours.	$50/visit/Covered Person credited toward Inpatient
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year

•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	20%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT

The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given or referred by the PCP	[NONE]
•if treatment, services or supplies are given by non-referred Provider	20%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by non-referred Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

COPAYMENT
If treatment, services or supplies are given or referred by the PCP

•Physician Visits	[$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]

CASH DEDUCTIBLE PER CALENDAR YEAR
If treatment, services or supplies are given by a non-referred Provider, or are not subject to a

Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]

EMERGENCY ROOM COPAYMENT $50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE 365 days, if preapproved.

SKILLED NURSING CARE 120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance

THERAPEUTIC MANIPULATIONS 30 visits/Covered Person.

THERAPY SERVICES

•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premiums Rate Changes."]

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.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.
b) the amount of any claims paid to You or Your Provider for Your claims 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

a) any Premium Due Date;
b) any date that the extent or nature of the risk under the Policy is changed:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

[PREFERRED PROVIDER ORGANIZATION PROVISIONS

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 We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (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 Provider, and he or she is free to change Providers at any time.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ Health Care Network] Provider or a non-[XYZ Health Care Network] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ Health Care Network] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] Provider. However, follow-up care or treatment by a non-[XYZ Health Care Network] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] Service Area.

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] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. 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] Provider will bill him or her directly.

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

What We pay is subject to all the terms of this Policy. You should read this Policy carefully and keep it available when consulting a Provider. See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You may contact Our [Claim Office at the number shown on Your identification card.]

[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.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
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 of Benefits 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 of benefits 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 Provider 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.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay 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 Copayment. When a Covered Person's PCP refers him or her to another [XYZ PO] Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ PO] Practitioners will prepare any necessary claim forms and submit them to Us

[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.]

[Once per Calendar Year, a female Covered Person may use the services of a [XYZ PO] gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

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]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ PO] Provider or a non-[XYZ PO] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ PO] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a [XYZ PO] Provider. However, follow-up care or treatment by a non-[XYZ PO] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ PO] Service Area.

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

Benefits
The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement. What We pay is subject to all the terms of this Policy.]

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals 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 Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [non MSA text]

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Calendar Year. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

[**Coinsurance Cap:** This Policy limits the Coinsurance amounts You must pay each Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Calendar Year exceed the individual cap, We waive Your Coinsurance 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 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.]**

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.]

[BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE [MSA text]

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care for each Calendar Year. Once any combination of persons in a family meets the Per Covered Family Cash Deductible shown in the "Schedule of Benefits" section of this Policy, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Calendar Year. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Out of Pocket Maximum: The Out of Pocket Maximums "Per Covered Person" and "Per Covered Family" are shown in the "Schedule of Benefits" section of this Policy. The Out of Pocket Maximums may only be satisfied with Covered Charges. In the case of single coverage, for a Covered Person, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Person must pay during each Calendar Year. Once the Per Covered Person Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year. In the case of coverage which is other than single coverage, for a Covered Family, the Out of Pocket Maximum is the maximum amount of Deductible *plus* Coinsurance such Covered Family must pay during each Calendar Year. Once the Per Covered Family Out of Pocket Maximum has been met during a Calendar Year, no further Deductible or Coinsurance will be required for any member of such Covered Family for the rest of the Calendar Year.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.]

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily Room and Board Limits during a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
b) Therapy Services;
c) medical social work;
d) nutrition services;
e) home health aide services;
f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
g) 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:

1) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2) The services and supplies must be:

•ordered by Your 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.

But payment is subject to all of the terms of this Policy and to the following conditions:

a) Your 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:
1) ordered by Your Practitioner;
2) 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 Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your 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.

We do not pay for:

a) services furnished to family members, other than the patient; or
b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill or terminally Injured under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill or terminally Injured Covered Person's death.

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

"Terminally Ill" or "Terminally Injured" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill or terminally Injured . It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies 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 Your Practitioner;
c) included in the Hospice care program; and
d) furnished 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;
d) treatment not included in the Hospice care plan; or
e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital-Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These Covered Charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting 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 Us.]

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy, and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hour, as appropriate, of inpatient care will not be covered if you, in consultation with the Practitioner, determine hat a shorter length of stay is medically appropriate.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 Us are Non-Covered Charges.**

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an accident) . All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if:
a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, 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 Policy.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Calendar Year, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are 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 do We cover orthodontic treatment.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Calendar Year. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.
EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does **not** affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Preventive Care: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Preventive Care. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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

These charges are not subject to the Deductible.

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 Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your body, or be needed due to a functional birth defect in a covered 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year per Covered Person for each of the following Therapy Services: Physical Therapy; Occupational Therapy; Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ) : We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Calendar Year. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: 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) Heart-Lung
g) Heart Valves
h) Pancreas
i) Allogeneic Bone Marrow

j) Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
•Leukemia
•Lymphoma
•Neuroblastoma
•Subject to Our prior written 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 Us in writing are Non-Covered Expenses.]**

[j) 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;
k) 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.]

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION OR IF WE ASK YOU TO OBTAIN A SECOND OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S) OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND NEITHER OF THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1 - Request For Care Preapproval
If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%. However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and appropriate, We will make payment as otherwise provided in this Policy.**

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2(a))
Hospice Care
Infusion Therapy

STEP 2 - Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care**, You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgment of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** or as soon as reasonably possible, from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are medically necessary and appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3- Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4 - Obtaining a Third Opinion

If You obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS CONFIRMS THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES .

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If You do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

ALTERNATE TREATMENT

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

Definitions

"**ALTERNATE TREATMENT**" means those services and supplies which meet both of the following tests:

a) They are determined, in advance, by Us 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 or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.

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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan
We 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, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) Us.

The 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:
•Us
•attending Practitioner
•Covered Person
•Covered Person's family, if any; and
d) estimated cost and savings.

If We, 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.

Exclusions
Alternate Treatment does not include services and supplies that We determine to be Experimental or Investigational.

[CENTERS OF EXCELLENCE

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

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

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

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

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

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

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT) , and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Policy; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose Intensive Chemotherapy, except as otherwise stated in this Policy.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth except as otherwise specifically covered.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury 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 by a Practitioner for surgery he or she performed on an Outpatient basis.

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

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators..

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre - Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents, except as stated in this Policy

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre - marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand - by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following:

a) Your beneficiary;
b) Your estate;
c) Your spouse;
d) Your Parents;
e) Your Children;
f) Your brothers and sisters; and
g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a) name(s) and address(es) of patient and Policyholder;
b) Policyholder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us 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 Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Injury.

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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We 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.

The repayment agreement shall 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 provide benefits under this Policy to or on behalf of a Covered Person to the extent such benefits services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

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 Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. 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 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law) .

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE POLICY
The entire Policy consists of:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Policyholder's application, a copy of which is attached to the Policy;
c) any riders, endorsements or amendments to the Policy; and
d) the individual applications, if any, of all Covered Persons.

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT
The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.
No change in the 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) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
c) if a change is required by [Carrier], it is accepted by the Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS
No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your 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.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE
During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends.
Termination by Request - If You want to replace this Policy with another Individual Health Benefits Plan, You must give Us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date for the new Plan, and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:
a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS
This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, 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 Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND OUT- NETWORK PROVIDER REIMBURSEMENT
Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out- Network Provider may be different than Our Network Provider Allowance; also, an Out- Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after You file 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS
By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[PROVIDER RELATIONSHIP
We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES
If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT
For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS
We will determine the share, if any, of Our divisible surplus allocable to this Policy as of each Anniversary Date, if this Policy stays in force by the payment of 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 You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

CONFORMITY WITH LAW
If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with the requirements of that law.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a).
Public Notice: Action on petition for rulemaking.
See: 28 N.J.R. 2413(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit D.
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate options for Sections III and V.
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN E
(New Jersey Individual Health Benefits E Plan)

Policy Term. The Policy takes effect on [_____], the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan E.

[Dividends are apportioned each year.]

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DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page [__].

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We 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.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE) . The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. **Note:** The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;

c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An Eligible Person who is insured under this Policy.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). 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. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Policy's age limit;
3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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 provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section, 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. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:
-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

FACILITY. A place We are 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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Policy, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

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. We 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. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;

b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited as a hospital by the Joint Commission;
b) approved as a Hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Out-of-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED.) All damage to a Covered Person's Body and all complications arising from that damage.

INPATIENT. You, if You are 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.

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. Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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 with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges]

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 EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Utilization Review Penalties are also Non-Covered Expenses.

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 Policy.

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

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay) .

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
a) as a Covered Person; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

POLICY. This agreement, [the Policy Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

POLICYHOLDER. The person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

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

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

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.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or
b) the negotiated fee.]

The Board may 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. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

[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. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or

c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) Any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Policy for only one person.
b) **FAMILY COVERAGE** - coverage under this Policy for You and Your Dependents.
c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Policy for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Policy for a Child or multiple Children who are members of the same household and who depend on the Policyholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE POLICYHOLDER** - You, if You are an Eligible Person, **except** as provided below.
b) **SPOUSE** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child, who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy **except** : a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident..

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of October, for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS POLICY
a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]..
c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.
d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Policy.

[SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•Mental or Nervous Conditions and Substance Abuse	25%
•Other Covered Charges -	10%
COINSURANCE CAP	After $1500/Covered Person,

$3,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:
•Non-Covered Expenses
•Cash Deductibles
•Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse
•Copayments

CASH DEDUCTIBLE PER CALENDAR YEAR

•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$150, $500, $1000]
per Covered Family	[$300, $1000, $2000]

EMERGENCY ROOM COPAYMENT $50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE 365 days, if preapproved.

SKILLED NURSING CARE 120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE $300/Covered Person (except newborns)
Newborns: $500 for their first year of life.
Not subject to Deductible and Coinsurance

THERAPEUTIC MANIPULATIONS 30 visits/Covered Person.

THERAPY SERVICES

•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (using Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT 365 days Inpatient Hospital care.

COINSURANCE:

•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	10%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT

The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person

COPAYMENT

If treatment, services or supplies are given by a Network Provider	
•[Physician Visits	$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]

CASH DEDUCTIBLE PER CALENDAR YEAR

If treatment, services or supplies are given by an Out-Network Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE
•for immunizations and lead screening for children NONE	
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE PPO (without Copayment)**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given by a Network Provider	[NONE]
•if treatment, services or supplies are given by an Out-Network Provider	10%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by an Out-Network Provider	25%

COINSURED CHARGE LIMIT
The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person
CASH DEDUCTIBLE PER CALENDAR YEAR	
•for Preventive Care	NONE
•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.

PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

[SCHEDULE OF BENEFITS **SAMPLE INDEMNITY POS**

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER CALENDAR YEAR BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED LIFETIME MAXIMUM BENEFIT UNLESS OTHERWISE STATED.

FACILITY BENEFIT	365 days Inpatient Hospital care.
COINSURANCE:	
•if treatment, services or supplies are given or referred by the PCP	[NONE]
•if treatment, services or supplies are given by non-referred Provider	10%, **except** as stated below
Exception: For Mental or Nervous Conditions and Substance Abuse charges if treatment, services or supplies are given by non-referred Provider	25%

COINSURED CHARGE LIMIT

The Coinsured Charge Limit means the amount of Covered Charges a Covered Person 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.

Coinsured Charge Limit:	$10,000 per Covered Person
COPAYMENT	
If treatment, services or supplies are given or referred by the PCP	
•Physician Visits	[$10 per visit]
•[Hospital Confinement	$100 per day, up to $500 per confinement, $1000 per Calendar Year]
•[Other	$10 per visit]
CASH DEDUCTIBLE PER CALENDAR YEAR	
If treatment, services or supplies are given by a non-referred Provider, or are not subject to a Copayment above	
•for Preventive Care	NONE

•for immunizations and lead screening for children	NONE
•for all other Covered Charges	
per Covered Person	[$500, $1000]
per Covered Family	[$1000, $2000]
EMERGENCY ROOM COPAYMENT	$50/visit/Covered Person credited toward Inpatient admission within 24 hours.
HOME HEALTH CARE	365 days, if preapproved.
SKILLED NURSING CARE	120 days of confinement/Covered Person, if preapproved.
HOSPICE CARE	Unlimited days, if preapproved.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS	Up to $5,000/Calendar Year combined Inpatient and Outpatient. Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.
PRESCRIPTION DRUGS	Subject to Cash Deductible and Coinsurance.
PREVENTIVE CARE	$300/Covered Person (except newborns) Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance
THERAPEUTIC MANIPULATIONS	30 visits/Covered Person.
THERAPY SERVICES	
•Physical Therapy	30 visits per Covered Person per Calendar Year
•Occupational Therapy	30 visits per Covered Person per Calendar Year
•Speech Therapy	30 visits per Covered Person per Calendar Year
•Cognitive Rehabilitation Therapy	30 visits per Covered Person per Calendar Year

Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy are covered as any other Illness; Infusion Therapy is subject to Our preapproval.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are [shown in the Policy's Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] [in the Policy's Schedule of Premium Rates] at the times and in the manner established by the provision of this Policy entitled "Premiums Rate Changes."]

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.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person 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 Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.
b) the amount of any claims paid to You or Your Provider for Your claims 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this Policy will continue in force during the grace period and this Policy will end when the grace period ends. However, We may deduct the amount of premium due for the period this Policy stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period. [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.]

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that the extent or nature of the risk under the Policy is changed:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the "General Provisions" section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

[PREFERRED PROVIDER ORGANIZATION PROVISIONS

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 We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network] Provider. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] Provider (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 Provider, and he or she is free to change Providers at any time.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ Health Care Network] Provider or a non-[XYZ Health Care Network] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ Health Care Network] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] Provider. However, follow-up care or treatment by a non-[XYZ Health Care Network] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] Service Area.

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] Provider furnishing covered services or supplies. Most [XYZ Health Care Network] Providers will prepare any necessary claim forms for him or her, and submit the forms to Us. 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] Provider will bill him or her directly.

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

What We pay is subject to all the terms of this Policy. You should read this Policy carefully and keep it available when consulting a Provider. See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You may contact Our [Claim Office at the number shown on Your identification card.]

[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.] We will supply the Covered Person with a list of PCPs who are members of the [XYZ Provider Organization].
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 of Benefits 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 of benefits 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 Provider 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.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay 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 Copayment. When a Covered Person's PCP refers him or her to another [XYZ PO] Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ PO] Practitioners will prepare any necessary claim forms and submit them to Us

[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.]

[Once per Calendar Year, a female Covered Person may use the services of a [XYZ PO] gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

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]. We will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

In the case of a Medical Emergency, a Covered Person may go to a [XYZ PO] Provider or a non-[XYZ PO] Provider. If a Covered Person receives care and treatment for a Medical Emergency from a non-[XYZ PO] Provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Medical Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a [XYZ PO] Provider. However, follow-up care or treatment by a non-[XYZ PO] Provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ PO] Service Area.

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

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Copayments applicable to the Point of Service arrangement. What We pay is subject to all the terms of this Policy.]

[APPEALS PROCEDURE

Carrier may elect to include information regarding an appeals 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 Department of Health and Senior Services and the New Jersey Department of Banking and Insurance, it may include that approved Appeals Procedure language in the standard IHC forms.]

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductible is shown in the "Schedule of Benefits" section of this Policy. The Deductible cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Calendar Year. Once a family meets the equivalent of two individual Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Calendar Year. The amount of Covered Charges applied toward the satisfaction of the family deductible cap by any one Covered Person may not exceed the amount of the individual Cash Deductible. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

[Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Calendar Year. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Calendar Year exceed the individual cap, We waive Your Coinsurance 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 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.]**

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Payment Limits: We limit what We pay for certain types of charges.

COVERED CHARGES

We will pay benefits if, due to an Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Calendar Year. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the "Schedule of Benefits", along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits 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 Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the "Schedule of Benefits" when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily Room and Board Limits during a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Dialysis Center Charges: We cover charges made by a dialysis center for covered Dialysis Therapy services.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. 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 meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
b) Therapy Services;
c) medical social work;
d) nutrition services;
e) home health aide services;
f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
g) 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:

1) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2) The services and supplies must be:

•ordered by Your 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.

But payment is subject to all of the terms of this Policy and to the following conditions:

a) Your 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:
1) ordered by Your Practitioner;
2) 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 Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your 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.

We do not pay for:
a) services furnished to family members, other than the patient; or
b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill or terminally Injured under a Hospice care program. Additionally, We cover charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill or terminally Injured Covered Person's death.

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

"Terminally Ill" or "Terminally Injured" means that Your Practitioner has certified in writing that Your 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 for meeting Your special needs if You are terminally Ill or terminally Injured. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies 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 Your Practitioner;
c) included in the Hospice care program; and
d) furnished 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;
d) treatment not included in the Hospice care plan; or
e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the "Schedule of Benefits". And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement. This Emergency Room Copayment must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

We also cover charges for a mother who is insured under this Policy and a newborn dependent for a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery or a minimum of 96 hours of in-patient Hospital care following a cesarean section delivery. These Covered Charges are not subject to the Medically Necessary and Appropriate requirements of this Policy. However, these charges are subject to the attending Practitioner determining that in-patient care is medically necessary, or the mother requesting 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 Us.]

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy, and

b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hour, as appropriate, of inpatient care will not be covered if you, in consultation with the Practitioner, determine hat a shorter length of stay is medically appropriate.

Nutritional Counseling: Subject to Our advance written approval, We cover charges for nutritional counseling for 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 Us are Non-Covered Charges.**

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Injury (but only if the treatment is given within 72 hours of an accident) . All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery, including Assistant Surgeon charges which are Medically Necessary and Appropriate. But, We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if:
a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs including contraceptives which require a Practitioner's prescription. Except as stated in the Mental or Nervous Conditions and Substance Abuse section of this Policy, 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 Policy.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Calendar Year, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. 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 cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Injury. But, except as covered under the "Preventive Care" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

CHARGES COVERED WITH SPECIAL LIMITATIONS

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 You are 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 do We cover orthodontic treatment.

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 an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Calendar Year. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits for the monitoring of a Covered Person's use of maintenance Prescription Drugs shall be treated the same as Practitioner office visits for the treatment of any other Injury or Illness for determining benefits under this Policy. Charges for maintenance Prescription Drugs shall be covered in accordance with the terms and conditions of this Policy concerning Prescription Drugs. Covered Charges for such office visits and maintenance Prescription Drugs are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions Limitations do not apply to a Dependent who is a newborn child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis..

Primary Care: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, immunizations, vaccinations, inoculations, x-ray, mammography, pap smear, Nicotine Dependence Treatment, lead screening and screening tests related to Preventive Care. However, except as specifically stated in this Policy, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductible or Coinsurance.

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

These charges are not subject to the Deductible.

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 Non-Covered Expenses.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written 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 Your body, or be needed due to a functional birth defect in a covered 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.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Calendar Year per Covered Person for each of the following Therapy Services: Physical Therapy; Occupational Therapy; Speech Therapy and Cognitive Rehabilitation Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ) : We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Calendar Year. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: 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) Heart-Lung
g) Heart Valves
h) Pancreas
i) Allogeneic Bone Marrow
[j) Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
•Leukemia
•Lymphoma
•Neuroblastoma
•Subject to Our prior written 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 Us in writing are Non-Covered Expenses.**]

[j) 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;
k) 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.]

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

UTILIZATION REVIEW

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION OR IF WE ASK YOU TO OBTAIN A SECOND OR THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU EITHER DO NOT OBTAIN SUCH OPINION(S) OR YOU DO NOT OBTAIN ONE CONFIRMING OPINION FROM EITHER THE SECOND OR THIRD OPINION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND NEITHER OF THE OPINIONS CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

C. NO REDUCTION IN BENEFITS OR PAYMENT WILL BE APPLIED PURSUANT TO THIS SECTION IF, FOLLOWING AN INITIAL DETERMINATION BY US THAT WE WILL NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES, YOU REQUEST RECONSIDERATION OF OUR DECISION AND WE SUBSEQUENTLY DETERMINE THAT THE HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IN SUCH AN EVENT, WE WILL MAKE PAYMENT AS OTHERWISE PROVIDED IN THIS POLICY.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the hospital admission, procedure, service or supply were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1 - Request For Care Preapproval
If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%. However, no reduction will apply if, following an initial Determination by Us that We will not authorize an in-patient admission, You request reconsideration of Our Determination and We subsequently Determine the in-patient admission to have been Medically Necessary and appropriate, We will make payment as otherwise provided in this Policy.**

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

MEDICAL PROCEDURES	DIAGNOSTIC PROCEDURES
Lower Back Medical Care	Cardiac Catheterization
	CAT SCAN
	Cystoscopy
	Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2(a))
Hospice Care
Infusion Therapy

STEP 2 - Notice Requirements
If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

(a) For **Non-Medical Emergency** hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for **maternity care**, You or Your Practitioner must contact Us **within the first 12 weeks of medical confirmation** of a pregnancy. We will send You or Your Practitioner Our acknowledgment of the pregnancy within 7 days.

(b) For **Medical Emergency** hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later)** , or as soon as reasonably possible, from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the hospital admission or procedure, services or supplies are medically necessary and appropriate. In such an event, We will make payment as otherwise provided in this Policy.

STEP 3- Obtaining a Second Opinion
You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may **require** that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN FOR AN INPATIENT ADMISSION OR PERFORMANCE OF THE PROCEDURE AND IF YOU PROCEED WITH THAT ADMISSION AND/OR PROCEDURE, ANY PAYMENT FOR FACILITY CHARGES AND/OR PERFORMANCE OF THE PROCEDURE WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4 - Obtaining a Third Opinion
If You obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF NEITHER THE SECOND NOR THIRD OPINIONS CONFIRMS THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES .

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 50% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If You do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

ALTERNATE TREATMENT

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

Definitions
"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Us 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 or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home.
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 burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan
We 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, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) Us.

The 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:
•Us
•attending Practitioner
•Covered Person
•Covered Person's family, if any; and
d) estimated cost and savings.

If We, 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.

Exclusions
Alternate Treatment does not include services and supplies that We determine to be Experimental or Investigational.

[CENTERS OF EXCELLENCE

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

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

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

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

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

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

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT) , and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Policy; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Dose Intensive Chemotherapy, except as otherwise stated in this Policy.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth except as otherwise specifically covered.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury 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 by a Practitioner for surgery he or she performed on an Outpatient basis.

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

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Nicotine Dependence Treatment, except as provided for under Preventive Care.

Non - Prescription Drugs or supplies, except:
a) insulin, needles and syringes, glucose test strips and lancets; and
b) colostomy bags, belts, and irrigators..

Nutritional counseling and related services, except as otherwise stated in this Policy.

Pre - Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents, except as stated in this Policy.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre - marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;

h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
n) which are specifically limited or excluded elsewhere in this Policy;
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the Policy.;
p) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand - by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

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 used to eliminate baldness.

CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following:
a) Your beneficiary;
b) Your estate;
c) Your spouse;
d) Your Parents;
e) Your Children;

f) Your brothers and sisters; and
g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:
a) name(s) and address(es) of patient and Policyholder;
b) Policyholder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a Covered Person.

If a Covered Person makes a claim to Us 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 Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Injury.

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 paid benefits and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid 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.

We 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.

The repayment agreement shall 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 provide benefits under this Policy to or on behalf of a Covered Person to the extent such benefits services or supplies would duplicate whole or partial payments, services or supplies such Covered Person received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this Policy and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Policy and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Policy and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Policy is the secondary plan. The primary plan (Medicare) pays first, without regard to this Policy. The secondary plan (this Policy) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

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 Policy.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When payment that should have been made by this Policy has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. 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 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law) .

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE POLICY
The entire Policy consists of:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Policyholder's application, a copy of which is attached to the Policy;
c) any riders, endorsements or amendments to the Policy; and
d) the individual applications, if any, of all Covered Persons.

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT
The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.
No change in the 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) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
c) if a change is required by [Carrier], it is accepted by the Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS
No clerical error by Us in keeping any records pertaining to coverage under this Policy will reduce Your 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.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY - RENEWAL PRIVILEGE

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends.

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

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

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give you at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. . Coverage ends at 12:01 a.m. on the date the first of these events occurs..

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

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, 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 Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND OUT NETWORK PROVIDER REIMBURSEMENT
Payment amounts, as specified in the "Schedule of Benefits", apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by an Out Network Provider may be different than Our Network Provider Allowance; also, an Out Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after You file 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS
By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[PROVIDER RELATIONSHIP
We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, he or she may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES
If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

PAYMENT AND CONDITIONS OF PAYMENT
For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

[DIVIDENDS
We will determine the share, if any, of Our divisible surplus allocable to this Policy as of each Anniversary Date, if this Policy stays in force by the payment of 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 You in cash unless You ask that it be applied toward the premium then due or future premiums due. Our sole liability as to any dividend is as set forth above.]

CONFORMITY WITH LAW
If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with the requirements of that law.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT F

This Contract has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Notice of Right to Examine Contract. Within 30 days after delivery of this Contract to You, You may return it to Us for a full refund of any Premium paid, less services provided. The Contract will be deemed void from the beginning.

[CARRIER]
HEALTH MAINTENANCE ORGANIZATION BENEFITS PLAN
(New Jersey HMO Health Benefits Plan)

Contract Term. The Contract takes effect on[_____,] the Contract Effective Date. The term of this Contract starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Contract. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Contract.

Renewal Provision. Subject to all Contract terms and provisions, including those describing Termination of the Contract, You may renew and keep this Contract in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Contract.

Premiums. We may only change the Premiums for this Contract if We change the Premiums for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this HMO Health Benefits Plan.

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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 You to understand what services are provided. Information about the services provided under this Contract begins on page ____.

ALCOHOLISM. Abuse of or addiction to alcohol.

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

[**ASSOCIATED MEDICAL GROUPS.** Any Medical Group with which we contract directly to provide Covered Services to Members including the [ ]].

BIRTHING CENTER. A Facility which mainly provides care and treatment 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 Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

It must also:
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 if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

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 treatment.]

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

[**COINSURANCE.** The percentage of Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered Services.]

CONTRACT. This agreement, [the Contract Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

CONTRACTHOLDER. The person who purchased this Contract.

CONTRACT TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Contract is renewed each one-year period thereafter.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Services or Supplies. Note: The Emergency Room Copayment, if any, must be paid in addition to any other Copayments and Coinsurance.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Contract. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability

insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Contract provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Contract's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Contract's age limit;
3) the Child became insured before the Child reached this Contract's age limit, and stayed continuously insured until the Child reached such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this Contract's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. 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.

DISCRETION/DETERMINATION /DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
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.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Contract for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your 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 Your 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 Your 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:

-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-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 or 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.

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.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:

a) for whom, as of the date on which he or she seeks coverage under this Contract, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;

c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Contract, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

[HEALTH CENTER (or HEALTH CARE CENTER) - Any place operated by or on behalf of an HMO where a [Network] [Participating] [Provider] [Practitioner] Provides 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 or reduce Hospital stays. The agency must be licensed by the state in which it operates, or 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 carries out its stated purpose under all relevant state and local laws, and it is:
a) approved for its stated purpose by Medicare ;
b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It carries out its stated purpose under all relevant state and local laws, and it is :
a) accredited as a hospital by the Joint Commission;
b) approved as a hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 for Substance Abusers or Alcoholics is not a Hospital. A specialty Facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Member's body and all complications arising from that damage.

INPATIENT. You, if You are 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.

[MAINTENANCE DRUG. A Prescription Drug used for the treatment of chronic medical conditions including but not limited to: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes(oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders.]

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.

Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

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, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

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 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.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. The Facility must carry out its stated purpose under all relevant state and local laws, and be:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, 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] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.]

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services.

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 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 Contract.

OUTPATIENT. You, if You are registered at a recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay). For the purpose of benefit limitations, Partial Hospitalization days are considered as Outpatient visits.

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Contract:
a) as a Member; and
b) with or without interruption of coverage.

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.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

PRACTITIONER. A person 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 which are covered by this Contract.

PREMIUM. The periodic charges due under this Contract which the Contractholder must pay to maintain this Contract in effect.

PRE-ADMISSION TESTING. Consultations, X-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Contract starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your 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 Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the exclusions section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Contract.

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 Practitioner specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates 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 Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] [or Health Center] that directs You 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 carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

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, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

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

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 carries out its stated purpose under all relevant state and local laws, and it is:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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 PRACTITIONER. 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.

SPOUSE. An individual legally married to the Contractholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. The Facility must carry out its stated purpose under all relevant state and local laws, and be:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

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) Reasonable and Customary pre-operative and post-operative care; or
d) any of the procedures designated by C.P.T. codes as surgery.

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 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 Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or
c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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 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.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Contract. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder and/or any Member, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Contractholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Contract for only one person.
b) **FAMILY COVERAGE** - coverage under this Contract for You and Your Dependent(s).
c) **ADULT AND CHILD(REN) COVERAGE** - coverage under this Contract for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Contract for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Contract for a Child or multiple Children who are members of the same household and who depend on the Contractholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE CONTRACTHOLDER** -You, if You are an Eligible Person, [who lives, resides or works in the designated Service Area in the State of New Jersey] **except** as provided below.
b) **SPOUSE** - Your Spouse [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract , **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Member, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Member is a Resident.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Contract if this Contract replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that Plan. We may require proof that the other coverage has been terminated.

b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Contract only during the open enrollment period which occurs each year during the month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS CONTRACT

a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Contract is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]

c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Contract.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR, UNLESS OTHERWISE STATED. BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

FACILITY BENEFIT	Unlimited days.
COPAYMENTS:	
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500 / Calendar Year.
OUTPATIENT	$15 Copayment/visit
PRACTITIONER SERVICES:	
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 the result of the emergency).
ALCOHOLISM:	
OUTPATIENT	$15 Copayment/visit for a maximum of 20 visits / Benefit Period.
INPATIENT	$150 Copayment/day for a maximum of 5 days / 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.
AMBULATORY SURGERY	$15 Copayment/visit.
BIRTHING CENTERS	$15 Copayment/visit.
HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE CHARGES	Unlimited days, if preapproved.
MATERNITY (PRE-NATAL CARE)	$25 Copayment/initial visit.
MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE:	
OUTPATIENT/ PARTIAL HOSPITALIZATION	$15 Copayment/visit for a maximum of 20 visits / Benefit Period.
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 or Partial Hospitalization Days.
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.
PREVENTIVE CARE	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if the Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CARE	Unlimited days, if preapproved.
THERAPEUTIC MANIPULATION	$15 Copayment/visit for a maximum of 30 visits per Calendar Year.
THERAPY SERVICES	$15 Copayment/visit.
X-RAY & LAB (OUTPATIENT)	$15 Copayment/visit.

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY CARE PHYSICIAN, CARE MANAGER OR HEALTH CENTER AS APPLICABLE. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS Contract CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Contract are [shown in the Contract's Schedule of Premium Rates]:

For Single Coverage	[$]

For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

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 "Premium Rate Changes:"]

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.

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 was included in the Premiums paid for the two-month period immediately after the date 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 You to Us. They are due on each Premium Due Date [stated on the first page of the Contract]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Contract is in force in order for this Contract to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period, [this Contract will continue in force without premium payment during the grace period and this Contract will end when the grace period ends.][coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.] [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.]

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Contract. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Contract will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Contract shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Contract as before the end of the grace period.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the [Premium Rates and Provisions section of the Contract] [Contract's Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) 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;

c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Contract.

We will give You 30 days written notice when a change in the Premium rates is made.

COVERED SERVICES AND SUPPLIES

You are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by You of applicable Copayments as stated in the applicable Schedule of Services.

a) **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] [Health Center] or [Care Manager]:

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by your Primary Care Physician.
3) **Periodic health examinations** to include:
    a) Well child care from birth including immunizations;
    b) Routine physical examinations, including eye examinations;
    c) Routine 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 Your employment).

4) **Diagnostic Services.**
5) **Casts and dressings.**
6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by Your [Primary Care Physician] [or Care Manager] and approved in advance by Us [or the Care Manager] .
7) **Infertility Services** except where specifically excluded in this Contract.
8) **Prosthetic Devices and Durable Medical Equipment** when ordered by your Primary Care Physician [or Care Manager] and arranged through Us. 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 Your body, or be needed due to a functional birth defect in a covered Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9) **Prescription Drugs** and contraceptives which require a Practitioner's prescription and the following non-prescription drugs and supplies: insulin needles and syringes and glucose test strips and lancets; colostomy bags, belts and irrigators
10) **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 Primary Care Physician and approved in advance by Us.

b) **SPECIALIST PRACTITIONER BENEFITS.** Services of a Specialist Practitioner are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office [, or Health Center] or at a [Network] [Participating] Hospital outpatient department during office or business hours upon prior written referral by Your Primary Care Physician [or Care Manager]

c) **INPATIENT HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] [Participating] Practitioner upon prior written referral from Your Primary Care Physician [Care Manager], only at [Network] [Participating] Hospitals and [Network] [Participating] Practitioners (or at [Non-Network] [Non-Participating] Facilities upon prior written authorization by Us); however, [Network] [Participating] Skilled Nursing Center benefits are limited to those which are Medically Necessary and Appropriate and which constitute Skilled Nursing Care:

1. Semi-private room and board accommodations

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

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if You, in consultation with the [Participating] Practitioner, determine that a shorter length of stay is medically appropriate.

As an exception to the Medically necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of n-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.

[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 Medically Necessary and Appropriate as certified by Your attending Practitioner in concurrence with your Primary Care Physician [or Care Manager] and approved in advance by Us. If You occupy a private room without such certification You shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] [Participating] Hospital or the [Network] [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
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services. We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts
20. Private duty nursing only when Medically Necessary and Appropriate as certified by the [Network] [Participating] Specialist Practitioner or other attending Practitioner in concurrence with Your Primary Care Physician [or Care Manager] and approved in advance by Us.

21. The following transplants, when Medically Necessary and Appropriate: Cornea, Kidney, Lung, Liver, Heart, Heart-Lung, Heart Valves, Pancreas.
22. Allogeneic bone marrow transplants.
[23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma Neuroblastoma, and Breast Cancer when approved in advance by Us, if You are 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] [Participating] Practitioner at Practitioner's office [, Health Center] or at a [Network] [Participating] Substance Abuse Center upon prior written referral by Your [Primary Care Physician] [[or] Care Manager].

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits or Partial Hospitalization days during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by Your Primary Care Physician [or Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medial ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by Your Primary Care Physician [or Care Manager], for up to sixty (60) more Outpatient visits or Partial Hospitalization days by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You 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. **Repeat Detoxification Treatment.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

Court-ordered Substance Abuse or Mental or Nervous Conditions admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as described above.

e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a [Participating Provider] [Network Practitioner] at Practitioner's office [, Health Center] or at a [Network] [Participating] Substance Abuse Center upon prior written referral by Your Primary Care Physician [or Care Manager].

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by Your [Primary Care Physician] [or Care Manager] for the abuse of or addiction to alcohol. 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. You are additionally eligible, upon referral by Your [Primary Care Physician] [or Care Manager], 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.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the Alcoholism, and referral services for Alcoholism. 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. **Repeat Detoxification Treatment.** Repeated detoxification treatment for chronic Alcoholism will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating] Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of Alcoholism services.

Court-ordered Alcoholism admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

f) **MEDICAL EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by Your Primary Care Physician [or Care Manager] in the event of a Medical Emergency as Determined by Us [or the Care Manager].

1. Your Primary Care Physician [or Care Manager] 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 Your health, You shall call Your Primary Care Physician [or Care Manager] [or Health Center] [or Us] prior to seeking Medical Emergency treatment.

2. We will cover the cost of Medical Emergency and medical Hospital services performed within or outside Our service area without a prior written referral only if:

a) Our review determines that Your symptoms were severe and delay of treatment would have been detrimental to Your health, the symptoms occurred suddenly, and You sought immediate medical attention. A near-term delivery is not a Medical Emergency.
b) The service rendered is provided as a benefit under this Contract and is not a service which is normally treated on a non-emergency basis; and
c) We and Your Primary Care Physician [or Care Manager] are notified within 48 hours of the Medical Emergency service and or admission and We are furnished with written proof of the occurrence, nature and extent of the Medical Emergency services within 30 days. You shall be responsible for payment for services received unless We Determine that Your 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 You are hospitalized in a [Non-Participating] [Non-Network] Facility, coverage will only be provided until You are medically able to travel or to be transported to a [Network] [Participating] Facility. If You elect to continue treatment with [Non-network] [Non-Participating] Providers, We shall have no responsibility for payment beyond the date You are determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the reasonable cost as Determined by Us. Reimbursement may be subject to payment by You of all Copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to the [Network] [Participating] Provider.

4. Coverage for Medical Emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after You have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or You shall be responsible for payment.

5. The Copayment for a Medical Emergency room visit will not apply in the event that You were referred for such visit by Your Primary Care Physician [or Care Manager] for services that could have been rendered in the Primary Care Physician's office or if You are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

g) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] [Participating] Provider upon prior written referral by Your 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 [Network] [Participating] Provider by Your Primary Care Physician [or Care Manager]. 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 Your Primary Care Physician [or Care Manager] certifies in writing that the treatment will result in a significant improvement of Your condition within this time period and treatment is approved in writing by Us.

2. Chelation therapy, Chemotherapy treatment, Dialysis treatment, Infusion therapy, Respiration therapy, and Radiation therapy.

HOME HEALTH BENEFITS. The following services are covered when rendered by a [Network] [Participating] Provider, including but not limited to a [Network] [Participating] Home Health Agency, as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of Your Primary Care Physician [or 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 You 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 Your medical condition.

4. Therapy Services as set forth above.

5. Hospice Care if You are terminally Ill or terminally Injured with life expectancy of six months or less. 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 appropriate care.

i) **THERAPEUTIC MANIPULATION.** The following services are covered when rendered by a [Network][Participating] 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. Services and supplies beyond 30 visits are not covered.

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Contract; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Dose Intensive Chemotherapy, except as otherwise stated in this Contract.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

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

Extraction of teeth, including bony impacted teeth.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider unless You were referred to the Provider by Your Primary Care Physician.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury which is covered or could have been covered for services provided under workers' compensation, employer's liability, occupational disease or similar law.

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

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Non-prescription drugs or supplies, except:
a) insulin needles and syringes and glucose test strips and lancets

b) colostomy bags, belts and irrigators.

Nutritional counseling and related services, except as otherwise stated in this Contract..

Pre-Existing Condition Limitations:
We do not cover services for Pre-Existing Conditions until You have been covered by this Contract for twelve months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition.
EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Contract, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does **not** affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Member who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Member: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Member was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Contract, measured from the last date the Creditable Coverage was in force on a premium paying basis.

[Prescription Drugs: We do not cover an initial prescription or refill that exceeds the lesser of: the amount prescribed by the Participating Provider and the amount shown below that applies to the Prescription Drug:

a) For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90)day supply.
b) For all other Prescription Drugs:

1) a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or
2) sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;
3) a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointment, enemas, etc.); or
4) one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or
5) one (1) vial containing no more than fifteen (15) milliliters of any optic or ophthalmic product; or
6) two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or
7) three(3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

a) dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or
b) dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

A Prescription Drug that is prescribed for injectable use, other than injectable insulin on prescription only, is not covered.

Allergy and biological sera, therapeutic devices or appliances are not covered as Prescription Drugs.]

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

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 or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
h) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
i) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
j) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
k) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
l) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Contract;
m) which are specifically limited or excluded elsewhere in this Contract;
n) which are not Medically Necessary and Appropriate, except as otherwise stated in the Contract.;
o) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Member (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Transplants, unless otherwise specifically covered, and non-human organ transplants.

Transportation; travel.

Vitamins and dietary supplements.

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 used to eliminate baldness.

APPEALS PROCEDURE

[Appeals Procedure: Variable by Carrier as approved by the State of New Jersey.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"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 or a 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 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 paid benefits or arranged [or provided] services or supplies and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

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.

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.

The repayment agreement shall 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 Member to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Member received 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.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Member may be covered under this Contract and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. We do this so the Member does not receive more in benefits, services and supplies than he or she incurs in charges.

Definitions

"Medicare" means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy 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 Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. 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 Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy 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 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 Contract and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this Contract and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Contract is the secondary plan. The primary plan (Medicare) pays first, without regard to this Contract. The secondary plan (this Contract) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We cover less than We would otherwise cover, We apply only that reduced coverage against payment limits of this Contract.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent 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 request this information from any source.

When coverage that should have been provided by this Contract has been provided by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that coverage. And if We provide more than We should have, We have the right to recover the excess coverage.

Small Claims Waiver
We do 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, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Contract, You have two options under the terms of Your motor vehicle insurance Contract. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Contract (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance policy or under similar provisions of a motor vehicle Contract required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Contract.

If You choose this option, We will provide benefits for any Covered Services and Supplies incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Contract.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Contract, this Contract will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

MEMBER PROVISIONS

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, or as may otherwise by provided by law, may not be disclosed without the Member's written consent.

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 Contractholder, coverage may be terminated for the Contractholder as well as any of the Contractholder'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 Appeal 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 [Network] [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.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No [Network] [Participating] Provider or other provider, institution, Facility or agency is Our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any [Network] [Participating] Provider or other provider, institution, Facility or agency.
2. Neither the Contractholder nor any Member is our agent, representative or employee, or an agent or representative of any [Network] [Participating] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. [Network] [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 Contractholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION ON SERVICES
Except in cases of Medical Emergency, services are available only from [Network] [Participating] Providers. HMO 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 [Network] [Participating] Facility to render services if hospitalization is necessary. Decisions as to Medical Necessity and Appropriateness are subject to review by the Quality Assessment Committee of HMO 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 Practitioner referred in writing by the Primary Care Physician [or Care Manager] without notifying the Member that such benefit would not be covered under this Contract.

REFERRAL FORMS
You can be referred for Specialist Services by Your Primary Care Physician [or Care Manager].

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician [or Care Manager].

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeal Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeal Procedure. We reserve the right to expedite the Appeal Procedure. If the Appeal Procedure results in a decision upholding position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeal Procedure, to terminate this Contract in accordance with Section IX. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT
A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS
HMO is entitled to receive from any provider of services to a Member such information HMO deems is necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Contractholder, for the Contractholder, and for all Dependents covered hereunder, authorizes each and every Practitioner who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of 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 Dependents must select a Primary Care Physician [and/or a Health Center].

You select a Primary Care Physician from Our Practitioners Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN
Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If You do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will cover 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 authorize Your treatment for a [Mental or Nervous Condition, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

GENERAL PROVISIONS

AMENDMENT
The Contract may be amended, at any time, without Your 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 an officer of [Carrier] has 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 an officer of [Carrier].
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 an officer of [Carrier].
c) if a change is required by [Carrier], 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 an officer of [Carrier].

ASSIGNMENT
No assignment or transfer by You of any of Your 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 Your 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. Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Contract.

CONFORMITY WITH LAW
If the provisions of the Contract do not conform to the requirements of any state or federal law that applies to the Contract, the Contract is automatically changed to conform with the requirements of that law.

CONTINUATION OF COVERAGE
If You die while this Contract is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Contract for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Contract provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

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 Your Spouse loses coverage due to a divorce, the Spouse may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Contract ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Contract will apply under the new coverage to the extent it remains unsatisfied.

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 You, shall be used in contesting the validity of Your coverage or in denying a claim for benefits after such coverage has been in force for two years during Your lifetime.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after You file 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.

If to You: 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 Your 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 You for attachment to this Contract.

CONTRACT INTERPRETATION
We shall administer this 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.

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 You, and We furnish a copy to You or Your 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 becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Contract. . Coverage ends at 12:01 a.m. on the date the first of these events occurs.

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

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE
During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Contract will end [when that period ends.][as of the end of the period for which premium has been paid.]
Termination by Request - If You want to replace this Contract with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end as of 12:01 a.m. on the effective date of the new

Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which Premiums have been paid. Then the Contract will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)
d) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may have become eligible for coverage.
h) [You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]

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.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT G

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
   (b) Medicare.
   (See item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:
1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

[COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1--Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2--Complete all information.

Section 3--Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4--This information is required. Please complete all information.

[Section 5--For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]--Applicant **must sign** this section and date this form or it will not be processed.

Section [6/7]--Completion of this section is optional.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].

2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].

4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]

6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]

7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]

8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under their parent's contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This section must be completed in its entirety.			BIRTHDATE			SEX	
LAST NAME	FIRST NAME	MI	MO	DAY	YR	M or F	Social Security Number
Applicant 1. o Add o Remove							__/__/__-__/__-__/__/__/__
Spouse 2. o Add o Remove							__/__/__-__/__-__/__/__/__
Child 3. o Add o Remove							__/__/__-__/__-__/__/__/__
Child 4. o Add o Remove							__/__/__-__/__-__/__/__/__
Child 5. o Add o Remove							__/__/__-__/__-__/__/__/__

*Attach sheet to list additional children. Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? o Yes o No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: a person :
   - whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
   - in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

Street _____ Apt._____ City _____ State _____ Zip _____

[Do you live, reside or work in the [Carrier's] service area? o Yes o No]

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: o Home o Work

Are you a resident of the State of New Jersey? o Yes o No

Do you maintain a residence in any other state? o Yes o No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): _____

Name of Carrier _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____]]

COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY FAMILY) IN: (Only one plan and one deductible option may be selected)

PLAN B [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $500_____$1000_____
PLAN C [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $1000 _____ $2500____
[$1500_____$2250___]
PLAN D [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $500_____ $1000 _____ [$1500_____
$2250___]
PLAN E [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $500 _____ $1000 _____

[HMO Plan [$10] $15 [$20] copayment.] [Well Child Care Option o Yes o No]

Type of Contract: o Single
o Family
o Adult & Child(ren)
o Husband/Wife
[o Child(ren)]

[If you selected Plan C or Plan D with a [$1500][[$2250] Deductible option, do you intend to participate in a Medical Savings Account?
o Yes o No]

Requested Effective Date - [Must be the 1st or 15th of the month]:_____

Type of Activity:

o New Subscriber

o Converting from existing (carrier) plan
ID #_____

o Add/Remove Dependent
Reason _____
Date of Event _____

o Name Change from _____ to _____

[o Change of Primary Care Physician or Gynecologist]

[o Change of Health [Care] Center from _____ to _____]

[o Change of Primary Care Physician at Health [Care Center]

o Withdrawal From Coverage
Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

o Monthly [o Quarterly] [o Semi-Annually]

[PAYMENT MODE:
o Check
o Money Order
o Credit Card Type_____ No. _____ Exp. Date _____
o Automatic Bank Draft (attach voided check)
o Other _____ Amount $ _____]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other family members become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed? o Yes o No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? o Yes o No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other family members eligible for coverage? If yes, specify.
Do you or other family members currently have any other health care coverage? o Yes o No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? o Yes o No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced._____ Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? o Yes o No If "Yes", attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?]
[Where? [carrier] of:]

[PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
a.	Alcoholism, Drug Abuse	____	____
b.	Arthritis	____	____
c.	Blood Disorder	____	____
d.	Back or Neck Disorder, Injury or Pain	____	____
e.	Cancer or Tumors	____	____
f.	Diabetes	____	____
g.	Gastro or Intestinal Disorder	____	____
h.	Heart Disorder or Condition or Chest Pain	____	____
I.	High Blood Pressure	____	____
j.	Kidney or Liver Disorder	____	____
k.	Lung or Respiratory Disorder	____	____
l.	Mental or Nervous Disorder	____	____
m.	Paralysis, Stroke or Epilepsy	____	____
n.	Does Pregnancy Exist Expected Due Date: _____	____	____

2. During the past 6 months, have you or any dependent to be covered:

		Yes	No
a.	been examined or treated by a physician or other		

	health care provider for any condition, illness or injury, other than as stated above?	____	____
b.	been advised to have treatment or surgery or testing that has not been done?	____	____
c.	been admitted to a hospital or other health care facility as an inpatient?	____	____
d.	taken prescribed medications?	____	____

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question	Name	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners
					]

PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	HEALTH CENTER* (if applicable)	[GYNECOLOGIST OFFICE NO.]	ESTABLISHED PATIENT	PRIMARY CARE PHYSICIAN CHANGE	HEALTH CENTER CHANGE
1. Applicant				o Yes o No	o	o
2. Spouse				o Yes o No	o	o
3. Child				o Yes o No	o	o
4. Child				o Yes o No	o	o
5. Child				o Yes o No	o	o
[Statewide Physician Network o Health Carrier o]						

When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.

[NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to [carrier] for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995, c.100. o Accept o Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [carrier] may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to [carrier or its assignee] information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to [carrier or its assignee.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside live or work within the [carrier] service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that [carrier] will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application [carrier] can cancel this contract [as of the original effective date][immediately].

Applicant's Signature: _____ Date Signed _____

Spouse's Signature_____ Date Signed _____

Preparer's Signature: _____ DOI License # _____ Date Signed _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

[6.] [7.] INCOME HOUSEHOLD

Completion of this section is optional. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance or coverage.

o under-$20,000 o $20-$29,999 o $30-$39,999 o $40-$49,999 o $50-$59,999 o $60,000 and above

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY / FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY / FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED _____ DATE _____		PIN# / GRP#

ST11798 HCFA-1500 BASCR 12-90 (OCR SC)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

EXHIBIT I

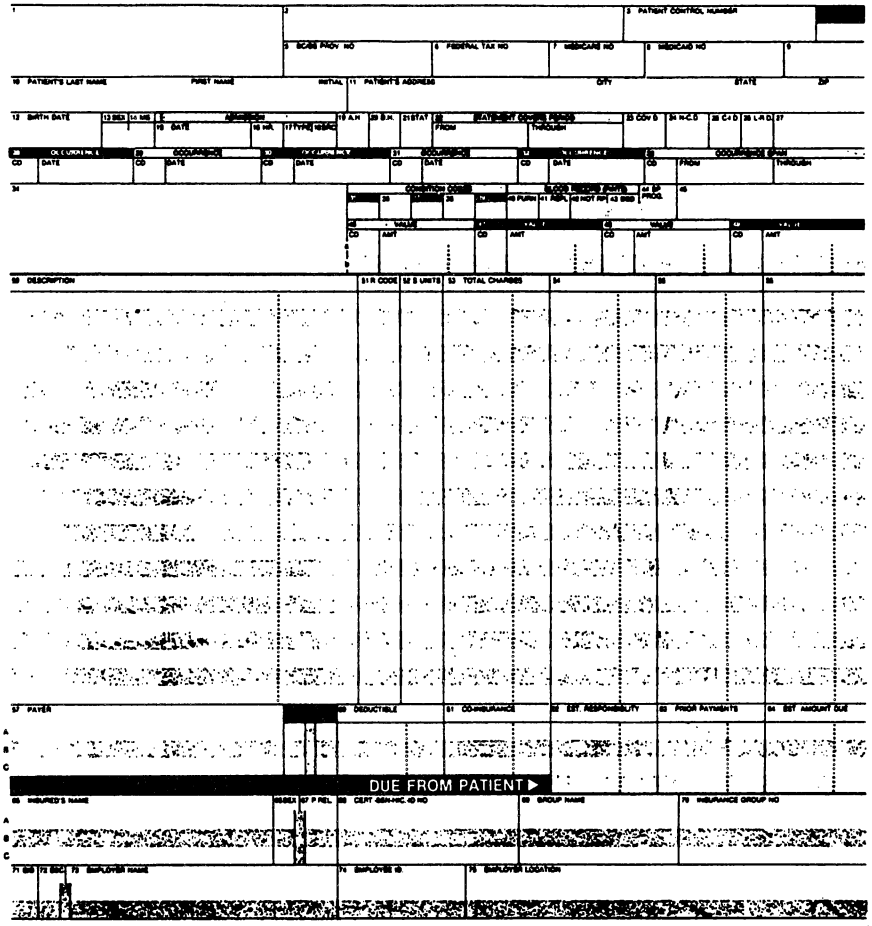

DUE FROM PATIENT ▶
NOTICE TO THE PATIENT
The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.
UB-82 HCFA-1450

EXHIBIT J

Loss Ratio Report Form New Jersey Individual Health Coverage Program
Reporting Year 19____, for the Preceding
Calendar Year Ending December 31, ____

Name of Carrier _____NAIC # _____
Address _____

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20-7, before you complete this Report.

A.	Net Earned Premium for Standard Health Benefits Plans	$ _____
B.	Total Losses Incurred (1 - 2 - 3 + 4 + 5 + 6) =	$ _____
1.	Claims paid during the preceding calendar year regardless of the year incurred;	$ _____
2.	Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;	_____
3.	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;	_____
4.	Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;	_____
5.	Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;	_____
6.	Pro rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20–2.17; [i × (ii÷iii)] =	_____
i.	Total net paid loss assessment	_____
ii.	Net earned premium for standard health benefits plans	_____
iii.	Net earned premiums for all health benefits plans	_____
C.	Loss Ratio (B÷A) = ____% (if less than 75%, fill out D and E below)	
D.	Amount entered on line B÷.75 =	_____
E.	Amount to be refunded to policy or contract holders (A-D) =	_____

If the amount entered on line C is less than 75%, you must attach to this Report a refund plan that conforms with N.J.A.C. 11:20-7.5. Please submit this form and a refund plan to the address listed in N.J.A.C. 11:20-2.1(h).

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 17B:27A-9e(1) and (2) and N.J.A.C. 11:20-7.

_____
Actuary's Signature

_____
Actuary's Name (Please print clearly)

_____
Title Date

_____
Telephone Number

Amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

EXHIBIT K
New Jersey Individual Health Coverage Program
Carrier Market Share and Net Paid Loss Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. In 1993, Reports must be completed and returned on or before June 28, 1993. Thereafter, Reports must be completed and returned on or before March 1 annually. Completed Reports must be returned to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Part A. Carrier Information

1. Carrier's Name: _____

2. Carrier's NAIC Number (including Group): _____

3. Is the specifically-named Carrier an affiliated Carrier?

____Yes ____No.

a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically-named Carrier?

____All Affiliated Carriers' combined Report
____Specifically-named Carrier's separate Report

b. If for all Affiliated Carriers, indicate the number of specifically-named Carrier Reports attached to this combined Report. _____

Part B. Personal Respondent Information

1. Name: _____

2. Title: _____

3. Telephone No: _____Facsimile No: _____

Part C. Calendar Year Information for _____
(year)

1. Net earned premium for all group and individual health benefits plans: $_____

2. Number of non-group persons enrolled by the Carrier:

a.	Community rated and modified community rated persons	_____
b.	Community rated conversion policy persons	_____
c.	Medicare cost and risk persons	_____
d.	Medicaid recipients	_____
e.	HealthStart Plus recipients	_____
	Non-group Total	_____

3. Net paid loss report for Individual Health Benefits Plans:

a.	PREMIUM EARNED Community rated and modified community rated	$
b.	CLAIMS PAID (-) Community rated and modified community rated	$
c.	EXPENSES (-) Community rated and modified community rated	$
d.	SUBSIDIES (+) (BCBSNJ only; 1992 only)	
e.	NET INVESTMENT INCOME (+) Community rated and modified community rated	$

f. NET PAID GAIN/(LOSS)
Community rated and modified community rated $_____

g. REIMBURSEMENT SOUGHT $_____
(For 1992: Limited to the Lesser of $10,000,000 or 50% of the Net Paid Loss)

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provision of N.J.A.C. 11:20–8.

_____ _____ _____
Signature Title Date

EXHIBIT L

Part 1

Carrier Name _____ Name of Person Completing Report _____

Year Ending _____ Telephone Number _____

Fax Number _____

Enrollment Status Report — Open Enrolled, Community Rated Individual Plans

Quarterly Statistics

Health Benefits Plan	Issued Prior to August 1, 1993	Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A. Report by Subscriber Contract													
I. Number of Contracts Inforce Beginning of Period													
II. New Issues and Conversions Issued in Period													
Total Number of New Contracts													
Contracts by Employment Status													
Number Employed													
Number Unemployed													
Number Unknown													
Contracts by Replacement Status													
Number Previously Insured													
Number Previously Uninsured													
Number Unknown													
III. Number of Contract Lapses in Period													
IV. Number of Contracts Inforce End of Period (I. + II. - III.)													
B. Report by Persons Insured (End of Period)													
I. Number Insured Beginning of Period													
II. Number of New Insureds During Period													
III. Number of Insureds Lapsed During Period													
IV. Number Insured End of Period (I. + II. - III.)													
C. Report of Contracts by Rating Category (End of Period)													
Number of Single Subscriber Contracts													
Number of Husband and Wife Subscriber Contracts													
Number of Parent and Child(ren) Contracts													
Number of Family Contracts													
D. Report of Contracts by Deductible/Copayment Option (End of Per.)													
Number of Subscriber Contracts with $150 or $250 Deduct or $10 Copay													
Number of Subscriber Contracts with $500 Deduct or $15 Copay													
Number of Subscriber Contracts with $1000 Deduct or $20 Copay													

Part 2

Annual Report Page 1

Carrier Name _____ Name of Person Completing Report _____

Year Ending _____ Telephone Number _____

Fax Number _____

Enrollment Status Report — Open Enrolled, Community Rated Individual Plans

Annual Statistics

Health Benefits Plan		Plan A		Plan B		Plan C		Plan D		Plan E		HMO Plan	Total
		Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS	Indemnity	PPO/POS		
A. Report of Contracts by Zip Code Categories													
Number of Subscriber Contracts in Zip Code Areas 070 073													
Zip Code Areas 074 075													
Zip Code Areas 076													
Zip Code Areas 077													
Zip Code Areas 078													
Zip Code Areas 079													
Zip Code Areas 080 084													
Zip Code Areas 085													
Zip Code Areas 086													
Zip Code Areas 087													
Zip Code Areas 088 089													
Total Subscribers													
B. Report of Covered Persons by Age and Sex													
Number of Male Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Number of Female Covered Persons Insured End of Period													
Age 0 to 20													
20 to 30													
30 to 40													
40 to 50													
50 to 60													
60 to 65													
65 to 70													
70 & Over													
Total Covered Persons End of Period													

Annual Report Page 2

C. Report of Salary Data														
Number of Subscriber Contracts														
Salary Under $10,000														
$10 to $20,000														
$20 to $30,000														
$30 to $40,000														
$40 to $50,000														
$50 to $60,000														
$60,000 & Over														
Total Subscribers														

New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

EXHIBIT M

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO Standard Plan Provisions".

EXHIBIT P

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT Q
CERTIFICATION OF COMPLIANCE

Submit this form in triplicate to the IHC Board at the following address: 20 West State Street, CN-325, Trenton, New Jersey 08625. Affiliated Carriers must file separate forms.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: _____
NAIC#: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
Respondent's Address: _____
Respondent's Telephone _____ FAX: _____

2. COMPLIANCE

Check all appropriate responses.

_____ (a) We are using the following forms which fully comply with the IHC Board's individual health benefits plan forms as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

_____ Plan A/Exhibit A
_____ Plan B/Exhibit B
_____ Plan C/Exhibit C
_____ Plan D/Exhibit D
_____ Plan E/Exhibit E
_____ HMO Plan/Exhibit F

_____ (b) Our application form complies with the IHC Board's form as set forth in Exhibit G in the Appendix to N.J.A.C. 11:20.

_____ (c) We are using an alternative application form pursuant to N.J.A.C. 11:20-4.1(b) and three copies of said form are hereby being submitted to the IHC Board for approval.

3. PLAN OPTIONS

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

(1) List all plans to be offered as traditional indemnity contracts, if any.

_____
_____
_____

(2) List all plans to be offered in conjunction with a selective contracting arrangement (defined as N.J.A.C. 11:4-37), if any.

_____
_____
_____

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the coinsurance differentials and whether the plan requires election of a primary care physician.

_____
_____
_____

(4) Do the plans provide for direct payment to health care practitioners without assignment? (Note: this option is available only on health service corporation plans and other plans offered in conjunction with selective contracting arrangements.)

___ Yes ___ No

(5) Do the plans include any of the following as set forth by the IHC Board?

i. Alternate Treatment Features
_____ Yes _____ No

ii. Centers of Excellence Features
_____ Yes _____ No

(b) HMO Plan

(1) Check the copayment options being offered.
$10 (Optional)
$15 (Standard)
$20 (Optional)

(2) Is the in-network prescription drug coverage being offered?
$15 Copayment
50% Co-insurance

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.

Date

Signature

Title

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Administrative Change.
See: 27 N.J.R. 1423(a).

EXHIBIT R

[Carrier]
MANDATED OFFER RIDER
[Policyholder]
[Policy No.]
Effective Date:

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in Plans B-E:

Item j. of the Transplant Benefits section of the COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is replaced with the following:

j. 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;

k. 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.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in the HMO Plan:

Item 23. of the INPATIENT, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS provision of the COVERED SERVICES AND SUPPLIES section of the Contract is replaced with the following:

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.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plan A should use the following text:

THE COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is expanded to include the following:

Transplants: We cover Medically Necessary and Appropriate Services and Supplies 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.

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

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 should insert standard amendment closure and signature blocks.]

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT S

[Carrier]
AMENDMENT
[Policyholder]
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.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

EXHIBIT T

Text which is enclosed in brackets may *only* be modified as described in this Exhibit. Unless otherwise stated, carriers have the option to either include or not include the standard text.

Plans B - E

1) The name of the Carrier, specific dates, page numbers, deductible amounts or premium information may be inserted, as appropriate.
2) **Dividend** text on the face page and in the General Provisions should only be included by mutual carriers.
3) The definition of **Care Manager** should only be included by carriers that utilize such a provider.
4) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee only if the plan is issued through or in conjunction with a Selective Contracting Arrangement.
5) Omit the **definitions** of Network Provider, Out-Network Provider and Service Area for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
8) Omit the **PPO, POS and Appeals** sections for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
9) The **Coinsurance Cap** provision in the Benefit Deductibles, Copayments and Coinsurance section should be included in plans which are *not* issued through or in conjunction with a selective Contracting Arrangement. Omit the Coinsured Charge Limit provision.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Hospital Charges** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available *via rider* should include the text of the first item "j" in the Transplant section. Omit the second item "j" and item "k". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "j" in the Transplant section. Include the second item "j" and item "k".
12) Carriers that do not use centers of excellence should omit the **Centers of Excellence** section.
13) Carriers may elect to omit the **Provider Relationship** provision in the General provisions.
14) Omit the **Network and Out-Network Provider Relationship** provision in the General Provisions for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
15) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Policy-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.
16) Carriers that issue Point of Service plans may elect to allow a female Covered Person to use the services of a **network gynecologist** without PCP referral for stated services on an unlimited basis, or may limit the use of a network gynecologist without PCP referral to once per year. Include only the paragraph in the Point of Service provisions which reflects the elected option.

Plans issued through or in conjunction with a **Selective Contracting Arrangement:**

1) Include the following definitions:
- Network provider
- Out-Network Provider
- Service Area

2) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee.
3) Sample **Schedule** text is included for a PPO plan without copayments, a PPO plan with copayments, and a POS plan. For plans which use copayments, include only the categories of services to which a copay will apply. The dollar amounts of the copayments should be consistent with the copayment options available with the IHC HMO plan.
4) Include the Preferred Provider Organization section if the plan is a PPO. Include the name of the PPO wherever XYZ appears.
5) Include the Point of Service section if the plan is a POS. Include the name of the provider organization wherever XYZ appears.
6) Carriers issuing a PPO or a POS plan may include **Appeals Procedures.**
7) Include the **Coinsured Charge Limit** text in the Benefit Deductibles, Copayments and Coinsurance section. The Coinsurance Cap provision should be omitted.
8) Include the Network and Out-Network Provider relationship provision in the General Provisions.

Plans issued with $1500 and $2250 **High Deductible Options** (that could be used in conjunction with an MSA):

1) Include only the **Schedule of Benefits** page which specifies the high deductible options. Omit all other schedules.
2) Include the **Benefit Deductibles, Copayments and Coinsurance** section which addresses the maximum out of pocket amount. Omit the corresponding section which addresses Coinsurance Cap/Coinsured Charge Limit.

HMO Plan

1) The name of the Carrier, specific dates, page numbers, copayment amounts or premium information may be inserted, as appropriate.
2) Wherever a series of terms are shown in brackets, select the term that is consistent with the carrier's terminology or practice.
3) Omit **Care Manager** definition if a care manager is not used.
4) Omit **Coinsurance** definition if prescription drugs are provided subject to a copayment.
5) Omit **Health Center** definition if not applicable.

6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) Carriers that require **that the person live, reside or work in the Service Area** as an eligibility criteria should include the bracketed text; and also include the bracketed termination text which addresses when a person no longer lives, resides or works in the Service Area.
8) Bracketed text is shown in the **Payment of Premiums-Grace Period** and **Termination of the Contract-Renewal Privilege** sections to accommodate termination as of the end of the grace period or as of the paid-to-date. Include appropriate bracketed text.
9) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Inpatient Hospital** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available via *rider* should include the text of the first item "23" in the Transplant section. Omit the second item "23" and item "24". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "23" in the Transplant section. Include the second item "23" and item "24".
12) The **Dispensing limits for prescription drugs** should be included in the Exclusions section by carriers that impose such limits.
13) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Contract-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.

Application

1) Omit those bracketed Instructions and bracketed text which do not apply.
2) Use the term Policy or Contract, as appropriate.
3) Use the term insured, subscriber or member, as appropriate.
4) Omit the quarterly and/or semi-annual premium payment modes if those modes are not available.
5) The use of the Pre-Existing Conditions Statement is optional.
6) The statement regarding the selection of a PCP may be included, at the option of the carrier.
7) The statement regarding the option to elect coverage for ABMT should only be included by those carriers that make the benefit available via rider.
8) The variable text a carrier includes in the statement regarding termination in the event of falsified information should be consistent with the election of the carrier regarding termination as of the effective date, or immediately. Refer to item 15 of the explanation for Plans B - E, and item 13 of the explanation for the HMO plan.

New Rule, R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).