CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

R.2006 d.15 and d.16, effective December 7, 2005.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a);
37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on December 7, 2010.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as 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).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rulemaking, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq.* See: 35 N.J.R. 2898(a).

Subchapter 22, Basic and Essential Health Care Services Plan, was adopted as R.2003 d.91, effective January 28, 2003. See: 34 N.J.R. 73(a), 35 N.J.R. 1290(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

Subchapter 4, Standard Application Form; Subchapter 5, Standard Claim Form and Appendix Exhibits G, H, and I, expired effective July 4, 2005. See: 37 N.J.R. 2994(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibit R, was repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23, Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a). See: Source and Effective Date. See, also, section annotations.

Case Note

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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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, as amended. 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, as the term member is defined in this subchapter, 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 August 1, 1993, 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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".

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 16.5).

"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.

"Basic and essential health care services plan" means the health benefits plan pursuant to P.L. 2001, c.368, N.J.S.A. 17B:27A-4.4 through 4.7.

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"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" (29 U.S.C. § 1002(33)).

"Commissioner" means the Commissioner of the New Jersey Department of Banking and 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.

"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.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means:

1. The applicant's spouse;

2. The applicant's same-gender domestic partner as that term is defined in P.L. 2003, c. 246;

3. The applicant's civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage;

4. A child or step child of the applicant;

5. A child of the applicant's domestic partner subject to applicable terms of the individual health benefits plan; or

6. A child of the applicant's civil union partner subject to applicable terms of the individual health benefits plan.

"Director" means a Director of the Individual Health Coverage Program Board who, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, §5:

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.

"Eligible person" means a person 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. §§1395 et seq.), "Medicare." An eligible person shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.

"Enrollment date" means, with respect to a Federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means the effective date of coverage under the individual health benefit plan.

"Family unit" means:

1. A legally married man and woman;

2. A person and his or her same-gender civil union partner;

3. A person and his or her same gender domestic partner;

4. A legally married man and woman and their dependent children;

5. A person and his or her same-gender civil union partner and their dependent children, as the term dependent is defined in the individual health benefits plan;

6. A person and his or her same gender domestic partner and their dependent child(ren), as the term dependent is defined in the individual health benefits plan;

7. An adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan, who are members of the same household; and

8. Dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

"Federally defined eligible individual" means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months during which time the eligible person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the eligible person has no creditable coverage);

2. 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;

3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. §§1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan;

4. 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;

5. Who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and

6. Who has elected continuation coverage described in 5 above and has exhausted that continuation coverage.

"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.).

"Fiscal year" means the time period beginning on July 1st of each year and ending on June 30th of the following calendar year.

"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" (29 U.S.C. §§ 1002(32)) 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" means a health benefits plan for groups of two or more persons.

"Group health plan" means an employee welfare benefit plan, as defined in Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care, and including items and services paid for as

medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall 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 (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan. 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;

7. The basic and essential health care services plan; and

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

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

"Hospital confinement indemnity coverage" means coverage that 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:

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

"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 of 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, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to N.J.S.A. 17B:27-49, 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 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; 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;; 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 an employee

welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1001 et seq.) preempts the application of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.) to that plan.

"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.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of a disease, illness, or medical condition or for the purpose of affecting any structure or function of the body; and

2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"Medicare" means coverage provided pursuant to Part A or Part B of 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.

"Medicare Plus Choice" means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

"Medicare Advantage" means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§1395 et seq.) and any amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid, NJ FamilyCare and NJ KidCare enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid, NJ FamilyCare and NJ KidCare net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare, Medicaid NJ FamilyCare and NJ Kidcare enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

"NAIC" means the National Association of Insurance Commissioners.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. 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 any Medicare, Medicaid, NJ FamilyCare or NJ KidCare contracts with the State or federal government, but shall not include any payment the Health Care Financing Administration makes on behalf of Medicare Plus Choice or Medicare Advantage enrollees, premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. §§8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L. 2000, c. 71 (N.J.S.A. 30:4J-1 et seq.).

"NJ KidCare" means the Children's Health Care Coverage Program established pursuant to P.L. 1997, c. 272 (N.J.S.A. 30:4I-1 et seq.).

"Non-group persons" or "non-group persons covered" means coverage by an individual health benefits plan or conversion policy or contract subject to P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), a basic and essential health care services plan pursuant to P.L. 2001, c. 368, Medicare cost or risk contract, Medicare Plus Choice or Medicare Advantage contract, Medicare Demonstration Project plan or Medicaid contract.

"Open enrollment" means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis, except as stated in N.J.A.C. 11:20-12.

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

"Plan sponsor" shall have 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. § 1002(16)(B)).

"Pre-existing condition" means a condition that, during a specified period of not more than six months immediately preceding the enrollment 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 enrollment 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.

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year. For purposes of identifying a Federally defined eligible individual, actual and intended presence in the State for a minimum period may not be considered, but a carrier may require an applicant to demonstrate that New Jersey is his or her primary residence as defined by law.

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

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

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".
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2000 d.142, effective March 6, 2000.
See: 32 N.J.R. 643(a), 32 N.J.R. 1253(c).
Rewrote "Member".
Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).
Inserted "Medicare Plus Choice"; in "Net earned premium", inserted reference to Medicare Plus Choice enrollees; and in "Non-group persons", inserted reference to Medicare Plus Choice contract.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Added "Basic and essential health care services plan"; in "Health benefits plan", added new 7, recodified former 7 as 8; in "Non-group persons", inserted "a basic and essential health care services plan pursuant to P.L. 2001, c.368" preceding "Medicare"; deleted "Reimbursement for losses".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "Basic health benefits plan" and "Reasonable and customary"; amended "Dependent", "Director", "Eligible person", "Family unit", "Member", "NAIC", "Net earned premium", "Non-group persons", "Pre-existing condition", and "Resident"; added "Enrollment date", "Federally defined eligible individual", "Medicare Advantage", "NJ FamilyCare", and "NJ KidCare".
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
In definition "Federally defined eligible individual", rewrote 1.
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Rewrote definitions "Dependent" and "Family unit".

11:20-1.3 Closing of noncomplying individual health benefits plan

(a) 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. 17:49-1 et seq., N.J.S.A. 17:48A-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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted the first sentence; and in (b), inserted N.J.S.A. references.

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, 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 this Act.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Deleted "including individual standard health benefits plans" following "this subchapter".

11:20-1.5 (Reserved)

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Inserted "plans" following "health benefits".
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Penalties".

11:20-1.6 Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested persons, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to individuals and establishing and administering assessment mechanisms. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

Repeal and New Rule, R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Severability".

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical 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, for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period thereafter pursuant to N.J.S.A. 17B:27A-12, as amended.

(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 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.

(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 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 address set forth below. Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
Telephone: (609)633-1882 x50306
Fax: (609) 633-2030

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), rewrote the introductory paragraph 2; and in (h), updated the address.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Changed subchapter heading from "Individual Health Coverage Program Temporary Plan of Operation". In (c) and (f), deleted references to the Temporary Plan of Operation; rewrote (h).

11:20-2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 as amended, 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.

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

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted a P.L. reference; and in (b), deleted "Basic health benefits plan", Deferral", "Director", "Financially impaired", "HMO", "Reasonable administrative expenses", and "Standard health benefits plan" definitions.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "Temporary Plan".

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 authority to do the following:

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

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;

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 filings and other filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and the Plan of Operation;

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

9. 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;

10. Appoint from among Board 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;

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

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

13. 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;

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

15. 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;

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

17. Impose interest penalties upon members for late payment of assessments as authorized by N.J.S.A. 17B:27A-10(f)(4);

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

19. 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;

20. 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 et seq.;

21. 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

22. 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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), substituted "authority" for "power" in the introductory sentence, deleted a P.L. reference in 4, and rewrote 6.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b).

11:20-2.4 Plan of Operation

(a) The Plan of Operation and amendments thereto shall become effective upon approval by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Plan of Operation 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 rescind the Temporary Plan.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), substituted "the Office of Administrative Law" for "OAL"; and in (b), deleted "amend or" preceding "rescind".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), substituted references to the permanent "Plan of Operation" for those to the "Temporary Plan" and substituted "approval" for "adoption"; section was "Temporary Plan of Operation".

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 or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L. 2001, c. 131 and is primarily engaged in the business of issuing health benefit plans in this State;

(2) A health maintenance organization;

(3) An insurer authorized to write health insurance in this State subject to Subtitle 17B of the New Jersey Statutes; and

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

ii. 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. A carrier may be placed on the ballot for only one Board position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board before the election as to the single position for which it will accept the nomination, and be designated on the ballot.

(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 via absentee ballot on or before the 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 and no two affiliated carriers shall serve on the Board at the same time.

(5) Elections shall be by the highest number of those votes 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.

iii. 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.

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 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. Appoint Directors to committees of the Board; and

3. 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 section 8 of P.L. 1993, c. 164, (N.J.S.A. 17B:27A-16.1) 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 Commissioner regarding amendments to the Act; and

vi. An assessment or interim assessment.

(e) All meetings of the Board at which a quorum is present, 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 and other reasonable 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. The Board shall retain the original of the minutes.

1. The staff of the Board 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; and

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

(j) All Board members shall be subject to the Individual Health Coverage Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote 2; in (c)2, deleted "and others persons"; rewrote (d)2iii; in (i), removed the requirement that copies of minutes be provided to the Commissioner.
Administrative correction.
See: 38 N.J.R. 1189(a).

11:20-2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors. 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; and

4. 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 for review of loss ratio reports;

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. Reviews of informational rate filings submitted to the Board pursuant to N.J.A.C. 11:20-6 to determine whether an informational rate filing is complete;

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

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

x. Any other reports or recommendations to the Board as may be appropriate regarding rates, rate filings and loss ratio reports, including, but not limited to, recommendations regarding the possible rating impact of suggested plan designs;

2. A Legal Committee, which shall make 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. Submissions by members of good faith marketing reports for the basic and essential health care services plan made pursuant to N.J.A.C. 11:20-22.6;

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. Materials to be distributed to consumers or made available through the Internet which describe the individual health benefits plans available to eligible persons pursuant to the Act.

4. An Operations and Audit 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;

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

vi. Methods for calculating assessments;

vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and

viii. 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.

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

(f) All committee members shall be subject to the Individual Health Coverage Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (d); and added a new (f).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), deleted "and IHC Program members" in the first sentence; in (b), deleted 4 and recodified former 5 as 4; rewrote (d) and (f).

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 into 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.

i. All investment income earned on administrative assessment funds shall be credited to the IHC Program and shall be applied to reduce future administrative assessments of members of IHC Program except as provided in N.J.A.C. 11:20- 2.12(h).

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce future loss assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17(h), and except that interest earned on loss assessment funds due to a carrier shall be paid to that carrier to the extent that the investment income is earned during a subsequent loss assessment cycle in which the carrier is no longer seeking reimbursement.

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Executive Director to make disbursements of less than $1,000 per disbursement for administrative purposes as necessary for the efficient administration of the program.

(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 Plan of Operation, 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 Executive Director shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by December 31 of each year beginning in 1998. 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 Board and the Commissioner on a quarterly basis.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (c), rewrote 2; in (d), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator"; and in (f), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator" and changed the delivery deadline from September 30 of each year beginning in 1994 to December 31 of each year beginning in 1998 in the introductory paragraph, and substituted "Board" for "Technical Advisory Committee" in 2.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), inserted "into" following "shall be deposited" in the introductory paragraph; in (c), rewrote 2; in (d), substituted "as necessary for the efficient administration of the program" for "subject to such conditions as the Board may prescribe"; in (e)4, deleted reference to the Temporary Plan.
Amended by R.2006 d.445, effective December 18, 2006.
See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).
In (c)2ii, substituted "(h)" for "(g)".

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 entities like the Board.

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 or Operations and Audit Committee, or both Committees, 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.

(c) The Board shall conduct a full or partial audit of a carrier filing for reimbursement of losses. Carriers filing for reimbursement of losses shall provide, within 90 days of the Board's written request such information as the Board shall request, including, but not limited to:

1. With respect to information regarding premium earned:

i. Detailed electronic data files of premiums which, in total, agree to the premiums earned reported to the IHC Board on the Exhibit K Assessment Report. The data file or files shall include sufficient detail to identify

the dollar amounts of premiums, by subscriber or contract number;

ii. All underwriting and premium records relating to the premiums earned on the data files, including, but not limited to, subscriber applications, billing records, cash receipt and disbursement records, advance premium and premium receivable records and rate filings;

iii. A reconciliation, if necessary, between the total premiums earned per the data files requested in (c)1i above and the premium earned amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iv. A reconciliation, if necessary, between the premiums earned amount reported to the IHC Board on the Exhibit K Assessment Report and premiums earned amount set forth in the Member's Annual Statement Blank filed with the Department or Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

2. With respect to claims paid:

i. Detailed electronic data files of claims paid which, in total, agree to the claims paid reported to the IHC Board on the Exhibit K Assessment Report. The data files shall include sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number. All claim file and disbursement records relating to the claims paid on the data file, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation;

ii. A reconciliation, if necessary, between the total claims paid per the data files requested in (c)2i above and the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iii. A reconciliation, if necessary, between the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report and the claims paid amount set forth in the Member's Annual Statement Blank filed with the Department or the Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

3. With respect to investment income:

i. Detailed schedules of net investment income which, in total, agree to the net investment income reported to the IHC Board on the Exhibit K Assessment Report. The schedules shall set forth the Member's calculation of net investment income allocated to the New Jersey individual line of business and shall include sufficient detail to identify the nature and source of the components used to calculate net investment income; and

ii. All source documentation used in the Member's calculation of net investment income, including, but not limited to, schedules used in the calculation of mean funds by line of business, cash receipt and disbursement records used in the cash flow schedules, and calculations for the Member's investment rate of return.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "or Operations Committee, or both Committees" following "Technical Advisory Committee" in 3; and added a new (c).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), substituted "entities like the Board" for "the type of entity" in 1 and inserted "and Audit" following "Operations" in 3; in (c), rewrote the introductory paragraph and updated references to Exhibit K of the chapter Appendix throughout; in (c)1ii, added a comma following "including"; in (c)1iv, substituted "forth" for "for".

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 Executive Director.

(b) The Board's records shall consist of 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;

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

9. 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 N.J.S.A. 47:1A-1 et seq., except that information in filings determined by the Board or Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection or copying.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), substituted "Executive Director" for "Interim Administrator and subsequently appointed Administrator"; in (b), deleted ", including rate and form filings, loss ratio filings, reports of net earned premium

and reports of net paid losses" at the end of 3, deleted 8, and recodified former 9 and 10 as 8 and 9; and rewrote (c).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (c), deleted "the Right to Know Law," following "pursuant to"; deleted (d).

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

2. The Board shall discuss amendments to the standard policy forms 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 amendments 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 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 Executive Director.

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

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.

(b) Members shall submit to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h), a certification, set forth as Exhibit E in the Appendix to this chapter, upon entry into the market and on March 1 of every year that sets forth that the standard policy forms will be used in accordance with the requirements of N.J.A.C. 11:20-3.2.

1. No member shall issue or renew a standard health benefits plan or the basic and essential healthcare services plan until a rate filing has been filed with the Board in accordance with N.J.A.C. 11:20-6.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Rewrote (a) and (b).

11:20-2.11 (Reserved)

Repealed by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Section was "Assessment for 1992 total reimbursable net paid losses".

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

(a) Except as described in (a)4 below, every member shall be liable for a portion of the administrative expenses of the IHC Program. Within 90 days of approving a final audited statement of the IHC Program financial statements and the conclusion of all appeals of assessments for administrative expenses, 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 applicable fiscal year or years. To the extent that an interim assessment has been made for that period, the notice shall provide reconciliation between the original invoice and the final invoice.

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 assessment for administrative expenses shall be reduced by any deferral assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

4. A member shall not be liable for an assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(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) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year. Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all members will be assessed based on 1997 and 1998 net earned premium. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Exhibit K Assessment 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 an Exhibit K Assessment 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 or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period.

(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, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Pursuant to N.J.S.A. 17B:27A-10(f)(4), 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 a member reports to the Board 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 identify the amount of the assessment in dispute and 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, which are set forth at 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 (f) above, to be held in an interest bearing 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 Executive Director 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 by the Board immediately, along with any applicable interest penalty amounts paid or interest earned while held 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 Executive Director 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 by the Board.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote introductory paragraph and added 4; in (c), updated references to Exhibit K of the chapter Appendix; in (f)1, added N.J.S.A. reference to the introductory paragraph and rewrote iii; in (f)2, added language requiring that members "identify the amount of the assessment in dispute"; in (g), added N.J.A.C. reference in the introductory paragraph; deleted references to an "escrow" account in (g) and (h); in (h)1, inserted "by the Board" following "may be disbursed".

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 Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Substituted "Executive Director at the address listed in N.J.A.C. 11:20-2.1(h)" for "Interim Administrator (or Administrator)".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "in order to preserve its right to any monies paid pursuant to the invoice of assessment" at the end of the paragraph.

11:20-2.14 Failure to pay assessments

If a member 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.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "is" following "If a member" in the first sentence.

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 pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(b) 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 any 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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a); deleted former (b) through (d); and recodified former (e) as (b).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), inserted "any" following "the assessment of" in the first sentence.

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, employee of the Board, 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 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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "employee of the Board" following "Directors".
Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "or the Department" following "of the Board" in the second sentence.

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998

(a) The Board shall assess members for reimbursable net paid losses, pursuant to N.J.S.A. 17B:27A-11a and 12, according to the procedures set forth in this Plan of Operation.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for each preceding two-year calculation period beginning in 1997/1998 based upon the information submitted by members in Part E of the Exhibit K Assessment Report, completed pursuant to N.J.A.C. 11:20-8 (formerly known as the Carrier Net Paid Gain (Loss) Report and set forth in a superseded version of Exhibit K to N.J.A.C. 11:20). The Board shall determine the preliminary total reimbursable net paid losses, if any, approximately 60 days after all IHC members have provided complete Exhibit K Assessment Report filings.

(c) The total reimbursable net paid losses for the preceding two-year calculation period shall be the aggregate of the reimbursable net paid losses for all members issuing individual health benefits plans, reporting net paid losses for that two-year calculation period, subject to any independent audit performed pursuant to N.J.A.C. 11:20-8.8. The loss assessment shall provide for full reimbursement of reimbursable losses, notwithstanding the granting of exemptions pursuant to N.J.A.C. 11:20-9. No member shall be entitled to reimbursement of net paid losses if the member has not issued individual health benefit plans during the two-year calculation period or if the member has applied for a conditional exemption for the two-year calculation period.

(d) Every member shall be liable for its proportional share of the total reimbursable net paid losses for the preceding two-year calculation period unless the Board has granted the member an exemption from assessments for the preceding two-year calculation period in accordance with N.J.A.C. 11:20-9.

1. The Board shall provide a preliminary written notice to members of the total of all members' reimbursable net paid losses for the preceding two-year calculation period and the amount of each member's anticipated loss assessment liability. This written notice shall be sent approximately 60 days after every IHC member has provided a complete Exhibit K Assessment Report as required by N.J.A.C. 11:20-8.

2. As necessary, the Board shall make adjustments to the preliminary notice of the loss assessment prior to issuing the loss-assessment invoice. Those adjustments may include, among other things, adjustments in market share, adjustments in net paid losses, and adjustments for deferrals granted pursuant to N.J.S.A. 17B:27A-12d(3) and N.J.A.C. 11:20-11.

3. The Board shall notify each member by invoice of its share of the loss assessment for the two-year calculation period. This invoice shall be sent approximately 60 days after the Board has completed its review of the Exhibit K Assessment Report filings for accuracy, including, but not limited to, consistency with other public filings provided to the State by the members.

4. The Board may issue interim assessments and reconciliations after the issuance of the loss-assessment invoice and before the issuance of the final reconciliation set forth in (d)5 below.

5. The Board shall notify each member of the final reconciliation of the loss assessment for the calculation period by issuing an invoice setting forth the dollar amount payable by the member or credit due to the member. The final reconciliation shall be issued approximately 90 days after all outstanding matters have been resolved, including but not limited to the completion of the independent audit of each member seeking reimbursement of losses, and the issuance of a final judicial determination of every appeal, including, but not limited to, those relating to the loss assessment for the two-year calculation period, exemptions from the loss assessment, independent net paid loss audits, and the payment of reimbursable losses. Any monies determined to be owed to or by the Board as a result of the final reconciliation shall be calculated without provision for interest.

(e) The Board shall determine each member's loss assessment share by multiplying the member's market share, as determined pursuant to (e)1 below, by the total reimbursable net paid loss amount for the two-year calculation period.

1. The Board shall determine each member's market share by dividing the member's adjusted net earned premium, as determined pursuant to (e)1i, (e)1ii, or (e)1iii below, for the two-year calculation period by the aggregate adjusted net earned premium of all members for the two-year calculation period.

i. For a member that has been granted a full exemption, the member's adjusted net earned premium shall be $0.

ii. For a member that has been granted a pro rata exemption, the member's adjusted net earned premium shall be calculated as the reported net earned premium in Part C of its Exhibit K Assessment Report multiplied by (100 percent minus the percentage of the non-group enrollment target the member satisfied).

iii. For a member that has not been granted a full or pro rata exemption, the member's adjusted net earned premium shall be the same as the net earned premium that the member has reported in Part C of its Exhibit K Assessment Report.

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

i. A member granted a deferral shall remain liable to the IHC Program for the amount deferred and for 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.

3. A member shall not be liable for a loss assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(f) Loss assessment amounts are due and payable upon a member's receipt of the invoice for the loss assessment. Payment shall be either by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, and sent to the address set forth in N.J.A.C. 11:20-2.1(h), or by wire transfer consistent with instructions in the invoice. The funds are deposited into the Board's account in Treasury.

1. Pursuant to N.J.S.A. 17B:27A-10f(4), members shall be subject to payment of an interest penalty on any loss assessment, or portion of a loss 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 loss assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of a loss 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, and the interest penalty shall continue to accrue on the unpaid amount.

iii. Good faith errors that members report to the Board 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 a loss assessment or any other error resulting in non-payment or underpayment of funds, the member shall make payment of additional amounts due within five days of identifying the good faith error.

2. A member that disputes whether it is subject to a loss assessment, or that disputes the amount of the loss assessment for which it has been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount shown on the assessment invoice, including any interest penalty accruing thereon. The member shall identify the amount in dispute, subject to verification by the Board. The Board shall not be liable for any misidentification by the member of the disputed amount that results in an insufficient amount being held by the Board. The disputed amount of the assessment shall be held in a segregated interest-bearing account until there has been a final adjudication of the dispute, or until such time as the Board determines that the member's appeal should be granted.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay a loss 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 a segregated interest-bearing 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 Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for assessments. 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 two-year calculation period, when the net paid loss audit is complete. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of loss 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 applicable two-year calculation period, until such time as the dispute has been resolved against the disputing member, or the deferral denied, except that any portion of a loss assessment not in dispute or subject to a 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 applicable two-year calculation period year in accordance with (h) above.

2. Upon receipt of notice that amounts of loss assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate 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 by the Board and provide notice to the member of the principal amount and interest amount. The Board shall calculate the amount to be returned to the member, which amount shall be paid within 30 days and shall include the payment of interest up until the date of the expected payment.

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
The expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.
See: 37 N.J.R. 2884(a).
N.J.A.C. 11:20-2.17 expired on December 31, 2005.
New Rule, R.2006 d.445, effective December 18, 2006.
See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $20.00, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

New Rule, R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(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 as follows:

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;

2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;

3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and

5. HMO Plan, Appendix Exhibit B.

(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 A/50, B, C, and D as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, except as provided in subsection (c) below.

1. Members offering Plans A/50, B, C, and D shall offer the following annual deductible provisions:

i. The per covered person annual deductible shall be $1,000; and

ii. The corresponding per covered family annual deductible shall be $2,000, satisfied on an aggregate basis.

2. Members offering Plans A/50, B, C, and D may offer one or more of the following annual deductible provisions in addition to the deductible provisions specified in (b)1 above:

i. Per covered person annual deductible equal to $2,500, $5,000 or $10,000; and

ii. Per covered family annual deductible equal to two times the applicable per covered person annual deductible, satisfied on an aggregate basis.

3. Members offering Plans A/50, B, C, and D may offer one or more of the following annual deductible provisions in addition to the deductible provisions required in (b)1 above:

i. In the case of single coverage, the greater of: $1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: $2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

ii. In the case of single coverage, $2,000, and in the case of other than single coverage, $4,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

iii. In the case of single coverage, $2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and in the case of other than single coverage, $5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted with single and other than single deductibles accumulated in accordance with the requirements of Federal law; and

iv. In the case of single coverage, $5,000, and in the case of other than single coverage, $10,000 with single

and other than single deductibles accumulated in accordance with the requirements of Federal law.

4. Members offering Plans C and D may renew plans that were issued with the following annual deductible provisions:

i. $1,500, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A)of the Internal Revenue Code per individual or in the case of a family unit, $3,000, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law; and

ii. $2,250, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, $4,500, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law.

5. When issued using deductible provisions set forth in (b)1 and 2 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. The per covered person maximum out of pocket for Plan A/50 shall be the sum of the annual deductible and $5,000;

ii. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and $3,000;

iii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and $2,500;

iv. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and $2,000;

v. The per covered family maximum out of pocket for Plans A/50, B, C and D shall be two times the per covered person maximum out of pocket, satisfied on an aggregate basis; and

vi. Coinsurance paid for covered prescription drugs under Plans A/50, B, C, and D, issued using deductibles set forth in (b)1 and 2 above shall not count toward the maximum out of pocket. Coinsurance for prescription drugs must continue to be paid even after the maximum out of pocket has been reached.

6. When issued using deductible provisions set forth in (b)3 above, Plans C, and D shall contain maximum out of pocket provisions as follows:

i. In the case of single coverage, the greater of $5,100 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $10,200 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted.

7. When renewed using deductible provisions set forth in (b)4 above, Plans C and D shall contain maximum out of pocket provisions as follows:

i. In the case of single coverage, $3,000 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code §220(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $5,500 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code Section 220(c)(2)(A) are permitted.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to Plans A/50, B, C, and D in (b) above. HMO carriers offering the HMO Plan shall offer the $15.00 copayment plan design set forth in (c)1i below and may, at the option of the HMO, also offer other copayments or may also offer the HMO plan using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments set forth below:

i. Members offering the HMO Plan shall offer the plan with a $150.00 per day hospital inpatient copayment, $100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $15.00 copayment for all other services, except that the copayment for pre-natal care may be $25.00 as required by (c)3ii below;

ii. In addition to the HMO plan required by (c)1i above, members may offer one or more of the following copayment arrangements:

(1) $300.00 per day hospital inpatient copayment, $100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $30.00 copayment for all other services, except that the copayment for pre-natal care may be $25.00 as specified in (c)3ii below;

(2) $400.00 per day hospital inpatient copayment, $100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $40.00 copayment for all other services, except that the copayment for pre-natal care may be $25.00 as specified in (c)3ii below; and

(3) $500.00 per day hospital inpatient copayment, $100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $50.00 copayment for all other services, except that the copayment for pre-natal care may be $25.00 as specified in (c)3ii below.

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, coinsurance and maximum out of pocket set forth below:

i. Members offering the HMO Plan may, in addition to the HMO plan required by (c)1i above, offer HMO Plans that include deductible and coinsurance provisions, subject to the following:

(1) The copayment for primary care physician services shall be: $15.00; $30.00; $40.00; or $50.00;

(2) The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care, or prescription drugs shall be $1,000 or $2,500 per person. The covered family deductible shall be two times the per person deductible, satisfied on an aggregate basis;

(3) The coinsurance, which shall not apply to services to which a copayment applies or to prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in 10-percent increments; and

(4) The maximum out of pocket shall be $5,000 per person, and for a covered family two times the per person maximum out of pocket.

3. Carriers issuing HMO plans, whether with copayment or Deductible and Coinsurance Design, shall include the following features which are common to all HMO plans:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be $100.00;

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $25.00, or equal to the copayment applicable to a primary care physician visit; and

iii. Prescription drugs covered under the HMO plan shall be subject to 50 percent coinsurance. For plans that include a maximum out of pocket, coinsurance for prescription drugs shall not count toward the maximum out of pocket and must continue to be paid after the maximum out of pocket has been reached.

(d) The standard health benefits Plans A/50, B, C, and D may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c. 162, §22. The standard health benefits Plans A/50, B, C, and D may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c. 162, §22, pursuant to N.J.A.C. 11:4-37.1(b), but is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through or in conjunction with an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements of P.L. 1993, c. 162, §22 shall be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6;

2. The network annual deductible shall be $1,000 or $2,500 per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The HMO Plan copayment amounts for physician visits, pre-natal care and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;

4. The coinsurance for network services shall be consistent with the coinsurance for one of Plans A/50, B, C, or D and the coinsurance for non-network services must be consistent with the coinsurance for one of Plans A/50, B, C, or D;

5. The network maximum out of pocket shall be $5,000 per covered person, and for a covered family shall be $10,000. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

6. If a separate non-network deductible is included, the non-network annual deductible shall be two times or three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis; and

7. If a separate non-network maximum out of pocket is included, the non-network maximum out of pocket shall be two times or three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket.

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (a), substituted "Individual" for "Basic" in 2, and added 7; in (b), inserted a reference to Plan A/50, deleted a reference to Plan E, inserted a reference to Exhibit U and substituted a reference to Exhibit D for a reference to Exhibit E in the introductory paragraph, deleted a reference to Plans B and E in the introductory paragraph of 1, and inserted a reference to Plans A/50 and B in the introductory paragraph of 2; in (c), substituted a reference to Plans A/50, B, C, and D for a reference to Plans B through E in the first sentence, and added 3; and in (d), inserted a reference to Plan A/50 in the first sentence, substituted a reference to Exhibit D for a reference to Exhibit E in 2, inserted a reference to $30.00 copayment levels in 3, and deleted ", and Plan E shall have an out-network level of 99 percent" at the end of 4.
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
In (b)3, rewrote i and ii.
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Added (b)4.
Amended by R.2002 d.331, effective October 7, 2002.
See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).
In (b)4, substituted "may" for "shall".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
In (b), added iii through vi in 3.
Repeal and New Rule by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

11:20-3.2 Certification of Compliance

(a) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification of Compliance set forth in the Appendix to this subchapter as Exhibit E, incorporated here by reference. Each affiliated carrier must file a separate Certification of Compliance. A Certification of Compliance must be filed upon entry into the individual market, and annually on or before March 1.

(b) Carriers that submit an Exhibit E Certification of Compliance may issue and make effective individual health benefits plans upon filing such Certification with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board. The Board may disapprove an Exhibit E Certification of Compliance if the Certification is inaccurate or incomplete.

(c) Any carrier whose Certification of Compliance is denied may file an appeal of the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (a), inserted a reference to Exhibit U; and in (b), deleted a reference to Exhibit E, and substituted a reference to Exhibit D for a reference to Exhibit E.
Repeal and New Rule by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Section was "Policy forms".

11:20-3.3 Compliance and variability rider

(a) 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 D 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) 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 and B of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit C, through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix.

(c) Members may incorporate text for benefits required to be offered to the Policyholder through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms to address the mandated offer that carriers may issue the optional coverage by rider in lieu of including the coverage in the standard policy forms. For example, coverage for autologous bone marrow transplant, as required to be offered pursuant to P.L. 1995, c. 100, may be included using the Compliance and Variability Rider.

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), inserted "as described in the Explanation of Brackets, Exhibit T," following "Chapter".
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (b), substituted a reference to Exhibit U for a reference to Exhibit F.
Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
In (a) and (b), substituted "Members" for "Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members", rewrote references to all Exhibits and added (c).

11:20-3.4 Plan update rider

(a) Members issuing new policy forms, as set forth in Exhibit A of the Appendix to this chapter, for renewal dates from July 1, 2006 through June 30, 2007, shall issue the Plan Update Rider, as set forth in Appendix Exhibit G, incorporated herein by reference. Such rider shall be issued to policyholders who:

1. Have coverage under Plans A/50, B, C or D on the day before the plan anniversary date which first follows July 1, 2006; and

2. Elect to renew Plan A/50, B, C or D, as applicable, with the same deductible amount, and copayment amount, if applicable, as issued by the same carrier.

(b) The Plan Update Rider shall expire at midnight on December 31 of the calendar year in which it was issued.

New Rule, by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Former N.J.A.C. 11:20-3.4, recodified as N.J.A.C. 11:20-3.5.

11:20-3.5 Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations and exclusions set forth in N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit F.

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Substituted "N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22" for "N.J.S.A. 11:20-22" and substituted "Exhibit F" for "Exhibit V".
Recodified from N.J.A.C. 11:20-3.4 by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

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 3 of the Act (N.J.S.A. 17B:27A-4) as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Inserted "as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368" following the N.J.S.A. references.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Substituted "section" for "sections 2b(1) and" and updated the N.J.S.A. reference.

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 rate filing requirements

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

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, sub-standard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c.368 and N.J.A.C. 11:20-6.5;

2. Monthly premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate fling, as of the stated effective date. Rates may be developed on different rate tiers for: single; two adults; adult/child(ren); and family; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses the use of the factors of age, gender and geography as discussed in (a)2i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care services plan shall include:

i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

iii. A detailed example calculation, in the proposal format used by the carrier, for the basic and essential health care services plan, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State;

Exhibit K Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment.

4. The Exhibit K Assessment Report along with the Premium Data Worksheet(s) and the Enrollment Data Worksheet(s) shall be filed together. For example, a carrier with three affiliates with reportable accident and health premium in New Jersey but only two of which issue non-group coverage, shall file one Exhibit K Assessment Report with the aggregated information for all affiliated carriers, three copies of the Exhibit K Part C Premium Data Worksheet, and two copies of the Exhibit K Part D Enrollment Data Worksheet.

(c) Certified Exhibit K Assessment Reports shall be submitted either by facsimile, with paper copy to follow by mail, or by hand delivery 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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), changed the report filing deadlines; and rewrote (b).
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Filing of the market share and net paid gain or (loss) report form".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (b)3, added "Exhibit K" preceding "Assessment Report" in the second sentence; rewrote (b)4; rewrote (c).

11:20-8.3 Calculation of net earned premium and determination of program membership for the two-year calculation period

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

(b) In Part C of the Exhibit K Assessment Report, each carrier with no net earned premium in the preceding two-year calculation period shall assert its status as a non-member by checking the box designated for non-members on the Exhibit K Assessment Report. Carriers either with no net earned premium or whose Section 3 Calculation of Net Earned Premium on the Exhibit K Part C Premium Data Worksheet is equal to 0 are non-members.

(c) Every carrier, whether a member or not, shall complete an Exhibit K Part C Premium Data Worksheet for each affiliate and shall attach each Worksheet to its Exhibit K Assessment Report.

1. In Section 1 of the Premium Data Worksheet, the carrier shall report the total accident and health premium reported on its annual statement blank for each calendar year of the two-year calculation period.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium in each calendar year of the two-year calculation period for each of the excepted types of coverage which are specifically identified in Section 2 of the Worksheet.

3. In Section 3 of the Premium Data Worksheet, the carrier shall calculate the affiliate's net earned premium by subtracting the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1 of the Worksheet.

4. The carrier shall report the aggregated two-year net earned premium on Exhibit K Part C by taking the sum of each affiliate's two-year net earned premium total as calculated on the Exhibit K Part C Premium Data Worksheet.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a).
Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).
In the introductory paragraph of (a), inserted N.J.A.C. reference, and in (a)1, inserted ", but not be limited to,".
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Net earned premium".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b); in (c), added "Assessment Report" at the end.

11:20-8.4 Calculation of average non-group enrollment for the two-year calculation period

(a) In Part D of the Exhibit K Assessment Report, each carrier shall report its aggregated average non-group enrollment for all affiliates for the preceding two-year calculation period.

(b) Each carrier shall complete an Exhibit K Part D Enrollment Data Worksheet for each affiliate that issued or renewed the categories of non-group enrollment listed on the worksheet and shall attach each Worksheet to its Exhibit K.

1. In Section a of the Enrollment Data Worksheet, the carrier shall report all community rated persons covered under individual health benefits plans, and all persons covered under as the basic and essential health care services plan as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters. For contracts issued prior to August 1, 1993, where a carrier'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; two adults = 2; adult and child(ren) = 2.8; family = 3.9. If a two adults category is not used, a

carrier shall use a composite factor of 3.33 in order to reflect the two adults category in the family factor.

2. In Section b of the Enrollment Data Worksheet, the carrier shall report all community rated conversion policy persons as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

3. In Section c of the Enrollment Data Worksheet, the carrier shall report all Medicaid recipients, including NJ KidCare Part A recipients and NJ FamilyCare Plan A recipients, but no recipients of any other plans through NJ KidCare or NJ FamilyCare, as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

4. In Section d of the Enrollment Data Worksheet, the carrier shall report all Medicare Plus Choice, Medicare Advantage, Medicare cost and risk lives and Medicare Demonstration Project lives as of the last day of the end of each calendar quarter during the Two-Year Calculation Period, and shall report the total of all eight quarters.

5. In Section e of the Enrollment Data Worksheet, the carrier shall calculate the two-year non-group enrollment total by adding the totals from a through d of the Worksheet.

6. In Section f of the Enrollment Data Worksheet, the carrier shall calculate the average two-year non-group enrollment to be reported on Exhibit K Part D by dividing the total two-year non-group enrollment total by eight.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Calculation of covered non-group persons".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b)1, substituted "two adults" for "husband and wife" throughout and substituted "composite" for "compromise"; in (b)4, substituted "Medicare Advantage," for "and".

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part E of the Exhibit K Assessment Report form, each member issuing individual health benefits plans shall provide data for its 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), or the basic and essential health care services plan pursuant to the requirements of P.L. 2001, c.368 for the preceding two-year calculation period. For purposes of completing Part E of the Exhibit K Assessment Report, a member that does not have any net earned premium for standard individual health plans or basic and essential healthcare services plans during a two-year calculation period shall not be considered to be issuing coverage, and thus shall not complete Part E and is not eligible for reimbursement.

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) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report premium earned. Premium earned shall be adjusted:

1. 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 bases, as appropriate to the member, from the member's NAIC annual statement, adjusted for the individual health benefits plan for which the report is being made, as necessary; and

2. To reflect the premium that a carrier should have earned based on charging premiums consistent with the rate filings the member filed with the board for the applicable time period.

(c) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report claims paid. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member based on the member's NAIC annual statement, adjusted as necessary for the individual health benefits plans for which the report is being made. Claims paid as reported on Exhibit K Assessment Report shall include reimbursement for charges made by providers for services and supplies, surcharges mandated pursuant to the New York Health Care Reform Act of 2000, P.L. 1999, c.1, codified in the New York Public Health law, section 2807-c through 2807-w, and network access fees where such fees may be demonstrated to have reduced specific claim payments and where the carrier has reported such fees as claims on its NAIC annual statement blank. In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be adjusted to only include claims that should have been paid according to the terms and conditions of the individual health benefits policy and N.J.S.A. 17B:27A-2 et seq.

(d) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits shall report its net investment income. Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K Assessment Report reporting, and notwithstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment income consistent with the following basis, adjusted for the

individual health benefits plans for which the report is being made as necessary.

1. The cost of granting and servicing premium notes and policy loans and liens shall be allocated to investment expense. The resulting net income on premium notes and policy loans and liens may be distributed to those lines of business which produced such income. In making such distribution, due consideration shall be given to the variation in the interest rate and incidence of expense on such notes, loans, and liens.

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. "Mean funds" refers to the average net cash flow balance over the two-year calculation period for which the calculation is being made, with the average net cash flow balance determined on a monthly or quarterly basis. The average net cash flow balance is the sum of the beginning of the month or quarter and end of month or quarter cash flow balances divided by two. The "cash flow balance" at the beginning of the month or quarter is equal to the inception to date paid premiums, plus the net investment income at the beginning of the month or quarter, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses. The "cash flow balance" at the end of the month or quarter is equal to the inception to date paid premiums, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid and less paid expenses, plus net investment income at the beginning of the month or quarter. "Inception to date" shall mean a measurement of cash flow from the first date the carrier receives premium for standard individual health benefits plans until the end of the most recent two-year calculation period.

(e) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report its net paid gain or net paid loss. The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits plans (as set forth on line b in Part E of Exhibit K), less 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans (as set forth in lines a and c, respectively, in Part E of Exhibit K). If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is greater than claims paid on individual health benefits plans, the amount shown of line d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line d represents a net paid loss.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote the introductory paragraph; in (c), added "Assessment Report" following "Exhibit K" in the third sentence; in (d), in the third sentence, added "Assessment Report" following "Exhibit K" and deleted the space between "not" and "withstanding"; in (d)2, added quotation marks around "Mean funds".

11:20-8.6 Certifications

(a) In Part F of the Exhibit K Assessment Report, the Chief Financial Officer, or other duly authorized officer of the carrier, shall certify that the Exhibit K Assessment Report, all Exhibit K Part C Premium Data Worksheets, and all Exhibit K Part D Enrollment Data Worksheets filed with the IHC Board are accurate and complete and conform with the requirements of this subchapter. Every duly authorized officer who provides a certification for the reporting required under this subchapter 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 of the year following every two-year calculation period that the net investment income reported on the Exhibit K Assessment Report has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, 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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "gain" preceding "(loss)" throughout; and rewrote (b).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Rewrote (a); in (b)1, substituted "the assessment" for "Exhibit K" following "reported on".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), inserted "Exhibit K" before the second occurrence of "Assessment Report"; rewrote (b).

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 Failure to file Exhibit K Assessment Report

(a) Failure to file in a timely manner the Exhibit K Assessment Report and certifications required by this subchapter shall result in the Board's using the premium set forth in the member's most recent Annual Statements filed

with the Department as the premium base to calculate that member's market share allocation of assessments for reimbursement of losses and minimum number of non-group persons.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "gain" preceding "(loss)" in the introductory sentence.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a), substituted "the Assessment Report" for "market share and net paid gain (loss) report" in the introductory paragraph.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section; section was "Penalties for failure to file market share and net paid loss report".

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 Exhibit K Assessment 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, except that, for loss periods beginning with 2001/2002, if the member fails to provide sufficient information to the auditor within 18 months after the auditor's first written request for records to enable the auditor to complete its audit, then the costs incurred after that time shall be the sole responsibility of carrier if the member should choose to proceed with seeking reimbursement of its losses and an audit. If a carrier fails to complete the audit within two years of the commencement of the audit, the Board may terminate the 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 two-year calculation period, 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. Such findings shall include the failure of a carrier to pay claims consistent with the terms of the applicable contract and applicable law, or to collect premiums consistent with the terms of its informational rate filing and applicable law. If the audit for any loss period beginning with 2001/2002 is terminated by the Board because the carrier did not cooperate in the completion of the audit within two years of the auditor's first written request for records, then the carrier shall not be entitled to reimbursement.

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), inserted "gain" preceding "(loss)" in the first sentence; and in (c), substituted "two-year calculation period" for "calendar year".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b), substituted "Assessment Report" for "market share and net paid gain (loss)report"; in (c), added the second sentence.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b) and (c).

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 file an appeal of the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Substituted "receipt of written notification of the Board's" for "the date that the IHC Program Board notifies the member of its".

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 (full 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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Inserted "full" preceding "or pro rata".

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 to the Board within 30 days after the date of receipt of the Board's notice of the member's minimum enrollment share for the applicable two-year calculation period. Written requests shall be submitted to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(b) A member's written request for an exemption 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 in New Jersey 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. 11:20-9.3;

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

i. Standard health benefits plans and the basic and essential health care services plan;

ii. Conversion policies issued pursuant to the IHC Act;

iii. Medicaid contracts, if offered, including NJ FamilyCare Plan A contracts and NJ KidCare Plan A contracts; and

iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice, Medicare Advantage and Medicare Demonstration plans 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 two-year calculation period for which an exemption is sought by the member.

(c) Within 45 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 a conditional exemption in writing, specifying the reasons for the denial. If the member's written request for an exemption is neither approved nor disapproved within 45 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 a conditional 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.

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of receipt of written notification of the Board's final determination, appeal the Board's determination and request a hearing, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b)2, rewrote i and iv.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (b), rewrote the introductory paragraph, rewrote 2iii., and added reference to "Medicare Advantage" in 2iv.; in (d)2, deleted ", as appropriate" at the end; rewrote (e).

11:20-9.3 Minimum enrollment share

(a) Approximately 60 days after all IHC members have provided complete Exhibit K Assessment Reports, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that two-year calculation period that the member must agree to cover in that two-year calculation period to qualify for an exemption from assessments for reimbursements for losses incurred in that two-year calculation period.

(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 Board shall calculate each member's minimum number of non-group persons by adding together the total number of persons covered under the plans set forth in (c)1 through 3 below on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, dividing by eight, and multiplying by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

1. Standard health benefits plans and the basic and essential health care services plan, and community rated, individually enrolled or insured plans issued prior to the IHC Act;

2. Conversion policies issued pursuant to the Act; and

3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A and NJ KidCare Plan A contracts.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a) and (c).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (c), deleted 1 and recodified former 2 as new 1.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a) and (c).

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 in New Jersey:

1. Standard health benefits plans and the basic and essential health care services plan;

2. Conversion policies issued pursuant to the Act; and

3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A and NJ KidCare Plan A contracts, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum 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)3 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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted former 3, and recodified former 4 as 3; and in (b), substituted "(a)3" for "(a)4" following "(a)1 through".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a), rewrote 1 and 3.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a)3, substituted ", Medicare Advantage contracts," for "and".

11:20-9.5 Procedures for granting or denying final (full or pro rata) exemptions

(a) So that the Board can determine whether the member has satisfied its minimum enrollment share, any member that has been granted a conditional exemption and seeks a final (full or pro rata) exemption shall file with the Board, on or before April 1 of the year following each two-year calculation period, a Certification of Non-Group Lives, in which it reports the number of non-group persons covered by that member on the last day of each calendar quarter of the preceding two-year calculation period, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives, Medicare Plus Choice lives, Medicare Advantage lives and Medicare Demonstration Project lives as described in N.J.A.C. 11:20-9.4(a)3 and (b). The member shall report separately the number of non-group persons in each category of non-group person 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 or if covered under a basic and essential health care services plan were enrolled on an open enrolled basis;

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

4. Were counted consistent with N.J.S.A. 17B:27A-12d(1) and (2);

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

6. Were issued a policy that was issued, or issued for delivery, in New Jersey.

(b) 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 (a) above.

(c) The IHC Program Board shall review, and may audit, a member's non-group persons reported pursuant to (a) 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.

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

(e) A member granted a conditional exemption shall be granted a full exemption from assessments for reimbursements for losses for the two-year calculation period in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to (a) above demonstrates that the member has enrolled or insured at least 100 percent of the minimum number of non-group persons allocated to it by the Board for that two-year calculation period.

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

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 granted 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.

(g) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of receipt of written notification of the Board's final determination, appeal the Board's determination and request a hearing pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

(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, including any interest that may accrue, until and unless there has been a final adjudication finding that the member qualifies for an exemption, or until such time as the Board determines that the member's appeal should be granted.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b), inserted "Medicare Plus Choice lives and Medicare Demonstration Project lives" preceding the N.J.A.C. reference in the introductory paragraph and rewrote 2.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.

Case Notes

Regulation giving pro rata exemption from Individual Health Coverage Program (IHCP) assessments to health insurance carriers that fell short of writing 50% of their target goal of individual policies, so long as they engaged in good-faith marketing efforts, conflicted with assessment scheme of Individual Health Insurance Reform Act; statute's pro rata assessment provision mandated assessment based on difference between target number and actual number of policies written. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Good-faith marketing requirements in Individual Health Coverage Program (IHCP) regulations were within authority of New Jersey Individual Health Coverage Program Board of Directors; Board's development of a program that gave incentives and required carriers to prove that they made a good-faith effort to enroll their target amount of individual or non-group policyholders was within the Legislature's intent in establishing Individual Health Insurance Reform Act. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

11:20-9.6 (Reserved)

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a); and in (c), substituted references to New Jersey individual health benefits plans for references to health benefits plans.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Inserted references to basic and essential health care services plans following references to health plans throughout.
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Good faith marketing report".

SUBCHAPTER 10. PERFORMANCE STANDARDS AND REPORTING REQUIREMENTS

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 in the year following the two-year calculation period.

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

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), substituted "in the year following the two-year calculation period" for "for calendar year 1993 and thereafter".

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. 11:20-2.17, shall provide a Performance Report to the IHC Program Board, no later than May 1, in the year following the two-year calculation period which contains a statement certified by member's Chief Executive Officer that:

1. The member's performance for the preceding two-year calculation period reflected good faith efforts to apply sound risk management principles in an efficient manner; and

2. 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.

(b) 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.

(c) A carrier shall not be eligible for any reimbursement of losses until a performance report is provided pursuant to (a)

above and has been found consistent with the requirements of (a) above by the IHC Board.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a); and in (b), deleted "1" following "(a)"; and added a new (e).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); deleted (b)-(c) and recodified existing (d)-(e) as (b)-(c).

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 appeal the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Substituted "receipt of written notification of the Board's" for "the date that the IHC Program Board notifies the member of its".

11:20-10.5 (Reserved)

Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Penalties".

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

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 (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.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), deleted an N.J.S.A. reference.

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 that 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, or a waiver of obligations pursuant to N.J.S.A. 17B:27A-8, as applicable.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (b), deleted "which, after December 20, 1993" following "member" in "Financially impaired" definition; and deleted an N.J.S.A. reference in "Relief" definition.

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) 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 Banking and Insurance
Division of Financial Solvency
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), deleted an N.J.S.A. reference; and in (f), updated the address.

11:20-11.4 Informational filing requirements

(a) When requesting relief from obligations imposed pursuant to N.J.S.A. 17B:27A-4 or 17B:27A-12, 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, telefax number and email address 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, signed by an actuary who is a member of the American Academy of Actuaries, 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 12 months immediately preceding the date of the filing;

10. 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 two-year calculation period for the subsequent two-year calculation period, 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 should 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."

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), deleted an N.J.S.A. reference in the introductory paragraph and rewrote 10.
Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
In (a)1iv, added "and email address" following "telefax number"; in (a)6, added ", signed by an actuary who is a member of the American Academy of Actuaries,"; in (a)9, substituted "the 12 months" for "the period beginning January 1 in the year of the filing to the quarterly statement"; in (b) and (c), made minor grammatical changes.

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., or the common law right to know, 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.

Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Added "or the common law right to know," to introductory paragraph (a).

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 does not have the financial reserves necessary to underwrite additional coverage or 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), 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.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), inserted "does not have the financial reserves necessary to underwrite additional coverage or" in the first sentence and deleted an N.J.S.A. reference.

11:20-11.7 Hearings

(a) A member may request a hearing on a determination by the Commissioner within 20 days from the date of receipt of such determination as expressly permitted by the chapter as follows:

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

i. The name, address, daytime telephone number, fax number and e-mail address 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 listing the disputed adjudicative facts warranting a hearing and describing the basis for the member's contention 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 disputed adjudicative facts.

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., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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 Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. If the Commissioner finds that the matter does not constitute a contested case, the Commissioner, with the approval of the Director of the Office of Administrative Law, may, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21.

iii. If the Commissioner finds that there are no good-faith disputed adjudicative 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.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), inserted "listing the material facts in dispute and" in 1iv and added a new 3ii.
Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Rewrote the section.

11:20-11.8 Notice to the IHC Program

Members requesting relief pursuant to this subchapter shall concurrently provide written notice of all such requests to the

IHC Program through the Executive Director. Members shall also provide written notice to the IHC Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition. All such notices shall be sent to the address set forth at N.J.A.C. 11:20-2.1(h).

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
Inserted "written" preceding "notice" throughout, and substituted "Executive Director" for "Interim Administrator or Administrator, as appropriate".
Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Deleted "of" from the section heading; added the last sentence.

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, pursuant to N.J.S.A. 17B:27A-8a:

(1) Will not offer coverage to or accept any new group members. Individual additions to existing groups shall not be considered new group members; and

(2) Upon denying individual health benefits coverage, will not offer such coverage in the individual market for a period of 180 days after the date the coverage is denied.

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

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
Rewrote (a)1iv.

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. PURCHASE OF A STANDARD INDIVIDUAL HEALTH BENEFITS PLAN OR A BASIC AND ESSENTIAL HEALTHCARE SERVICES PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR ELIGIBLE FOR OR COVERED UNDER A GROUP PLAN

11:20-12.1 Purpose and scope

This subchapter sets forth the standards for purchasing a standard individual health benefits plan or a basic and essential healthcare services plan by a person who is covered under an individual plan, and standards for purchasing a standard individual health benefits plan or a basic and essential healthcare services plan by a person who is either covered by or eligible to participate in a group health benefits plan.

11:20-12.2 Definitions

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

"Covered under an individual plan" means a person is covered under a standard individual health benefits plan, or a basic and essential health care services plan or under an individual plan issued prior to August 1, 1993.

"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 to the employee's dependents, if any, that the employee is a member of a class of persons eligible for coverage, works at least the minimum

number of hours required for coverage and that the employee has been employed for at least the minimum period required by the employer to be eligible for coverage, and the employee's dependents have satisfied all lawful standards for participation in the group health benefits plan. With respect to group coverage issued by an HMO carrier, a person who resides outside the HMO's service area shall not be considered eligible to participate in a group health benefits plan.

"Group health benefits plan" means a health benefits plan as defined in N.J.A.C. 11:20-1.2 as well as a self-funded health benefits plan for groups of two or more persons.

"Open enrollment period" means the calendar month of November 1 through November 30 of each calendar year, beginning in 2006, and annually thereafter.

"Same as or similar to the individual plan" means the group plan under which a person is covered or eligible to participate features cost sharing provisions consistent with those in the standard individual health benefits plan or basic and essential healthcare services plan for which the person has made application.

1. For a plan that uses coinsurance and deductible cost provisions, this means the coinsurance percentage in the group plan is identical to the coinsurance requirement in the individual plan and the deductible under the group plan differs from the deductible in the individual plan by no more than $100. When comparing coinsurance provisions in a plan that features network and non-network benefits, the coinsurance and deductible applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

2. For a plan that uses copayment provisions, this means the copayment for primary care services under the group plan is either: the same as the copayment for primary care services under the individual plan; or less than $10 more or less than the copayment for primary care services under the individual plan. When reviewing copayment provisions in a plan that features network and non-network benefits, the copayment applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

3. In addition to 1 and 2 above, for contributory group plans, the group plan is only the same or similar to the individual plan if the employee's share of the cost for the group plan differs from the cost of the individual plan by $100.00 or less per month.

4. Notwithstanding 1 and 2 above, for group plans that are closed panel HMO plans, the group plan is not the same or similar to the individual plan if the provider network for the group plan is not the same as the provider network for the individual plan.

11:20-12.3 Covered under an individual plan: replacement at any time

(a) Except as stated in N.J.A.C. 11:20-12.4(c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with the same type of plan using the same or greater deductible, same or greater coinsurance or same or greater copayments from another carrier, where there is no lesser deductible, coinsurance or copayment.

(b) Except as stated in N.J.A.C. 11:20-12.4(b) or (c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with any standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is less than the monthly premium for the existing standard individual health benefits plan.

(c) A person who is covered under a basic and essential health care services plan without rider may elect at any time to replace the plan with a basic and essential healthcare services plan without rider.

(d) A person who is covered under an individual plan issued prior to August 1, 1993 may elect at any time to replace the plan with a standard individual health benefits plan or a basic and essential healthcare services plan.

(e) The existing standard health benefits plan, basic and essential healthcare services plan or plan issued prior to August 1, 1993 must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

11:20-12.4 Covered under an individual plan: replacement only during Open Enrollment Period

(a) A person who is covered under a standard individual health benefits plan may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan.

(b) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan with an HMO plan featuring a lower copayment.

(c) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan with non-HMO plan. However, a person whose initial purchase in the individual market is an HMO plan may elect, at any time during the 90 days following the effective date of the individual plan, to replace the HMO plan with a non-HMO plan.

(d) A person who is covered under a basic and essential healthcare services plan without a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a rider.

(e) A person who is covered under a basic and essential healthcare services plan with a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a different rider.

(f) The effective date of the replacement plan issued as a result of items (a) though (e) above will be January 1 of the year following the Open Enrollment Period.

(g) The existing standard health benefits plan, basic and essential healthcare services plan must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

(h) Notwithstanding (a), (b) (d) and (e) above, a person covered under a standard individual health benefits plan or a basic and essential health care services plan may elect to replace the standard individual health benefits plan or a basic and essential health care services plan with a standard individual health benefits plan that is a high deductible health plan sold in conjunction with a Health Savings Account, at any time during the 60 days following the date a high deductible health plan is first made available by the carrier to whom the person makes application for the high deductible health plan.

11:20-12.5 Covered under or eligible to participate in a group health benefits plan

(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment period to be covered under a standard health benefits plan or a basic and essential healthcare services plan. The effective date of the individual plan will be January 1 of the year following the Open Enrollment Period.

(b) A person who is covered under or eligible to participate in a group health benefits plan that is the same as or similar to the individual plan for which the person has applied is not eligible to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(c) A person who is covered under a group plan pursuant to State or Federal continuation laws may elect at any time to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(d) When an application for individual coverage is made during the Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on December 31 immediately prior to the effective date of the standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of coverage under the group plan is not before the effective date of the standard individual health benefits plan or basic and essential healthcare services plan, the standard individual health benefits plan or basic and essential healthcare services plan shall be of no force and effect and premium paid shall be refunded.

SUBCHAPTERS 13 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

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 or renew standard health benefits plans or the basic and essential health care services plans to individuals.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b), inserted "or renew" following "issue" and "or the basic and essential health care services plans" following "benefits plans".

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 the 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.

"Insured" or "insured individual" means any individual covered under an individual health benefits plan.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), added new "Conversion", "Insured" or "insured individual" and "Replacement contract" definitions.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "Conversion" and "Replacement contract" and rewrote "Insured".

11:20-17.3 Filing requirements

(a) Every member of the IHC Program issuing or renewing standard health benefits plans and the basic and essential health care services plan 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 the information set forth in N.J.A.C. 11:20-17.4 and 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.

(c) Members shall file enrollment status reports on an annual basis reflecting the number of contracts by zip code category, and insured persons by age and gender category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of the prior year.

(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.

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "or renewing" following "issuing"; rewrote (b) and (c); and deleted (f).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a), inserted "and the basic and essential health care services plans" following "standard health benefits plan".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "hard copy" following "Members shall file"; in (c), substituted "gender" for "sex" and "the prior" for "each".

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 for Plans A/50, B, C and D, the HMO plans reported by copay or coinsurance, as well as indemnity, PPO, EPO or HMO coverage under the basic and essential health care services plan, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. In section A of Part 1 of Exhibit L, Report By Contracts shall be calculated by adding the number of contracts in force at the beginning of the period to the number of contracts issued during the period, and subtracting the number of contracts lapsed during the period.

i. Contracts issued shall be reported according to previous insured status. Previous insured status shall be separated into three categories: previously insured, previously uninsured, and unknown. Previous insured status shall be obtained from the section of the application that requires the applicant to indicate if the applicant had previous 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 uninsured. If the question has not been answered, the contract shall be reported as unknown.

2. In section B of Part 1 of Exhibit L, Report By Persons Insured 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; two adults = 2; adult and child(ren) = 2.8; family = 3.9;

3. In section C of Part 1 of Exhibit L, Report of Contracts By Rating Tier shall be reported separately by rating tier, that is: single; two adults; adult and child(ren); and family; and

4. In section D of Part 1 of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A/50, B, C, and D or the required and permitted copayment options for the HMO Plan. Members issuing PPO plans shall report according to the copayment or deductible applicable to network physician visits. Members issuing HMO plans that include deductible and coinsurance provisions shall report according to the deductible applicable to services and supplies for which coinsurance applies. Members issuing basic and essential health care plans shall report contracts for plans issued with and without riders.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken down by indemnity or PPO for Plans A/50, B, C and D, the HMO plans, as well as the indemnity, PPO or EPO or HMO basic and essential health care services plan, both with and without any rider:

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by Territory A – F or the first three digits of the zip code;

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year; and

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a) and (b).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
In (a) and (b), inserted references to indemnity for Plan A/50 in the introductory paragraphs.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a) and (b), inserted references to indemnity or HMO coverage under the basic and essential health services plan following "HMO plans" in the introductory paragraph.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.

11:20-17.5 (Reserved)

Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Penalties".

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

11:20-18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers issuing plans pursuant to the IHC Act may cease doing business in the individual plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing and renewing: all individual 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 individual plan market in New Jersey, that seek to cease offering or renewing individual plans issued pursuant to the IHC Act, 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.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a) added "issuing plans pursuant to the IHC Act" following "by which carriers" in the first sentence and added "and renewing" following "may cease issuing" in the second sentence; in (b), added "issued pursuant to the IHC Act" following "plans"; substituted "individual" for "standard individual health benefits" throughout.

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 withdrawal.

"Individual plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c.368, including any rider offered with such a plan.

"Pre-reform plan" means an individual health benefits plan issued in New Jersey prior to August 1, 1993.

"State" means the State of New Jersey.

"Market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all individual plans and nonrenewal of all in force individual plans and pre-

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval. The member shall submit:

1. A copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20- 2.1(h);

2. A copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change;

3. A certification signed by a duly authorized officer of the member that states clearly that:

i. The member shall make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

ii. Rates for the rider amending the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6;

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D "Covered Charges" or "Charges Covered with Special Limitations" sections of the policy or set forth in the standard HMO "Covered Services and Supplies" section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board's rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier's standard A/50 through D plan or standard HMO plan, as applicable.

(c) The Board shall notify a member in writing of its determination whether the rider filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

(d) A member seeking to challenge the Board's disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later 60 days following the close of each calendar quarter:

1. For standard indemnity plans, standard PPO plans, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total in force) reporting both number of contracts and number of lives as of the last day of the calendar quarter; and

2. For basic and essential health care services plans issued during the calendar quarter with a rider, the carrier shall submit:

i. The number of persons enrolled who were previously uninsured; and

ii. For all persons previously insured, the numbers of persons whose prior source of coverage was group; COBRA/state continuation; standard IHC plan; unridered basic and essential health care services plans plan, or other basic and essential health care services plans with rider.

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year:

1. For standard indemnity plans, standard PPO plans, standard HMO plans, basic and essential health care services plans, plans issued without a rider, and all basic and

essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b)1, substituted "A" for "One"; in (b)3, added iv-vi; added (b)4; added (d)-(i).

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan.

(b) The report shall include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier provides a certification in which it certifies that it either did or did not use any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (c)1ii, deleted "may" in the second sentence; in (c)1iii, substituted "provides a certification in which it certifies that it either did or did not use any" for "certifies whether it used any".

11:20-22.7 Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S.A. 17B:30-1.

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1 Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C. 11:20-23.6 is to establish procedures for public notice

regarding Board meetings. The purpose of N.J.A.C. 11:20-23.7 is to establish the procedures that the Board uses in placing parties and entities on the Board's in interested parties mailing list.

(b) N.J.A.C. 11:20-23.2 through 23.5 shall apply only to rulemaking of the Board made pursuant to New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and shall not apply to rules made pursuant to N.J.S.A. 17B:27A-16.1, a special rulemaking procedure set forth in the IHC Act. N.J.A.C. 11:20-23.7 shall apply to any person that wishes to be placed on the Board's interested parties mailing list.

11:20-23.2 Public notice regarding proposed rulemaking

(a) The Board shall provide the following types of public notice for rule proposals pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance web site at: http://www.njdobi.org and in the Department of Banking and Insurance's Library, which is located on the 1st Floor 20 West State Street, Trenton, NJ 08625.

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance web site; and

4. Notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of interested parties by e-mail or hard copy.

11:20-23.3 Extension of the public comment period

(a) The Board, pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicate a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

11:20-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);

2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and

3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

11:20-23.5 Public notice of new rules, amendments, repeals or adoptions

The Board shall provide notice of new rules, amendments, repeals or adoptions by posting these rules on its website at

http://www.nj.gov/dobi/reform.htm and to the news media maintaining a press office in the State House complex.

11:20-23.6 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting a notice at the office of the Secretary of State;

2. Posting a notice at the office of the Board at the address set forth at N.J.A.C. 11:20-2.1(h);

3. Posting of a notice on the Department of Banking and Insurance web site at: http://www.njdobi.org; and

4. Posting of the notice in two newspapers of general circulation designated by the Board.

11:20-23.7 Board mailing list of interested parties

(a) For the purpose of disseminating information about the IHC Program, including, but not limited to, information about meeting dates and rulemaking made pursuant to either the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. or N.J.S.A. 17B:27A-16.1, the Board shall maintain a mailing list of member carriers and other interested parties.

1. The mailing list of members shall be based upon the members addresses filed with its most recently filed Exhibit K Assessment Report.

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 in (a)1i above, the name and mailing address of a member shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member.

2. Persons other than member carriers who wish to receive communications from the Board, including, but not limited to, proposed rules, actions and public notices, may send a written request to the IHC Board at the address set forth at N.J.A.C. 11:20-2.1(h) 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.

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering and issuing health benefits plans to any eligible person.

11:20-24.2 Eligibility and issuance

(a) The policyholder of a standard health benefits plan or a basic and essential health care services 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 of New Jersey, but may not reside outside of the United States.

(b) A person shall not be eligible to be covered by a standard health benefits plan or a basic and essential health care services plan, as the policyholder or a dependent, if the person is eligible for Medicare, a group health benefits plan, group health plan, governmental plan, or church plan, except as provided in N.J.A.C. 11:20-12.5, or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20-12.3 and 12.4. After obtaining coverage under a standard health benefits plan or a basic and essential health care services plan, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare.

(c) A carrier shall not require a person or persons who are eligible for coverage under more than one rate tier to obtain coverage under any specific rate tier. For example, a carrier shall not require a married couple to apply for two adult coverage, if the husband and wife wish to obtain separate coverage.

(d) A carrier shall issue an individual health benefits plan to any eligible person who requests it and pays the premiums therefor, except that an HMO carrier may refuse to issue coverage to an eligible person that does not live in the carrier's approved service area, and except as provided in N.J.A.C. 11:20-11 and 12.

(e) Persons shall be accepted for coverage by any carrier without any restrictions or limitations on coverage related to their risk characteristics or those of their dependents, except that a carrier may exclude coverage for preexisting conditions consistent with the applicable terms of the individual health benefits plan.

11:20-24.3 Payment of premium

(a) A carrier may offer a credit card payment option or an automatic checking withdrawal option to individuals for the

monthly or quarterly payment of premiums. In the event that a carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all individuals.

(b) A carrier may offer a discount to individuals that pay premium on a quarterly basis.

(c) A carrier shall accept payment in the form of a check, a money order, a cashier's check, or cash.

11:20-24.4 Effective date of coverage

(a) A carrier, prior to issuing an individual health benefits plan, may require the following:

1. A completed individual application form;

2. Proof of the applicant's residency; and

3. Premium payment not to exceed one month's premium, which shall be refunded to the individual if the health benefits plan is not issued by the carrier.

(b) A carrier shall make coverage effective no later than the 1st or the 15th of the month, which ever comes first, after the receipt of the information set forth in (a) above that it may require. However, if a carrier allows additional effective dates and an applicant request a later effective date, a carrier shall make coverage effective no later than such requested effective date.

(c) With respect to applications submitted during the November open enrollment period, the effective date of coverage shall be January 1 of the following calendar year.

11:20-24.5 Paying benefits

(a) In paying benefits for covered services under the terms of the individual health benefits plans provided on an out-of-network basis by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges, except as required by applicable law including, but not limited to, N.J.A.C. 11:22-5.6(b). Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowable charge shall be based on the 80th percentile of the profile.

2. Carriers shall update their databases within 60 days after receipt of periodic updates released by Ingenix.

APPENDIX

EXHIBIT A

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 [A/50] [B] [C] [D].

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN [A/50] [B] [C] [D]
(New Jersey Individual Health Benefits [A/50] [B] [C] [D] 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.

EFFECTIVE DATE OF POLICY: [January 1, 2005]

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.

In consideration of the application for this Policy and of the payment of premiums as stated herein, We agree to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in New Jersey and is governed by the laws thereof.

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

[Secretary President]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Covered Persons]]

POLICY INDEX

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN A/50]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 50%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year [$6,000, $7,500, $10,000, $15,000]
[Per Covered Family per Calendar Year [$12,000, $15,000, $20,000, $30,000]
Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A/50

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan A/50]
Calendar Year Cash Deductible
for Preventive Care NONE
for immunizations and
lead screening for children NONE
For all other Covered Charges
Per Covered Person $1,000
Per Covered Family $2,000

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 50%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year $6,000
[Per Covered Family per Calendar Year $12,000
Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]

Hospital Confinement Copayment

- per day	$200
- maximum Copayment per Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000

Note: The Hospital Confinement Copayment is payable in addition to the applicable Deductible and Coinsurance and Copayment, if any.

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$4,000, $5,500, $8,000, $13,000]
Per Covered Family per Calendar Year	[$8,000, $11,000, $16,000, $26,000]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN B

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan B]
Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

Hospital Confinement Copayment

- per day	$200
- maximum Copayment per Period of Confinement	$1,000
- maximum Copayment per Covered Person per Calendar Year	$2,000

Note: The Hospital Confinement Copayment is payable in addition to the applicable Deductible and Coinsurance and Copayment, if any.

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year $4,000
Per Covered Family per Calendar Year $8,000
Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN C]

Calendar Year Cash Deductible
for Preventive Care NONE
for immunizations and
lead screening for children NONE
For all other Covered Charges
Per Covered Person [$1,000, $2,500, $5,000, $10,000]
Per Covered Family [$2,000, $5,000, $10,000, $20,000]

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 30%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year [$3,500, $5,000, $7,500, $12,500]
Per Covered Family per Calendar Year [$7,000, $10,000, $15,000, $25,000]
Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN C

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan C]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 30%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$3,500
Per Covered Family per Calendar Year	$7,000

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

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 20%

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

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$3,000, $4,500, $7,000, $12,000]
Per Covered Family per Calendar Year	[$6,000, $9,000, $14,000, $24,000]

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

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

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan D]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

Emergency Room Copayment

(waived if admitted within 24 hours)	$100

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows: 20%

Maximum Out of Pocket

Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$3,000
Per Covered Family per Calendar Year	$6,000

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **Example High Deductible health plan text that could be used in conjunction with an MSA or and HSA**

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Note to carriers: Use the following text for MSA plans	
•for all other Covered Charges	
[per Covered Person	[$1,500] [$2,250]] [Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[1550, $2300]]
per Covered Family	[$3,000] [$4,500[Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[3050, $4600]

Note to carriers: Use the following text for HSA plans

•for all other Covered Charges	
[per Covered Person	[the greater of: $1,200 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$2,000] [$2,800 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$5,000]]
[per Covered Family	[the greater of: $2,400 or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$4,000] [$5,600 or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$10,000]]

Coinsurance

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

The **Coinsurance** for this Policy is as follows: [30%, 20%]

Maximum Out of Pocket

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

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

Note to carriers: Use the following text for MSA plans

per Covered Person	[$3,000] [Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[3050].]
per Covered Family	[$5,500] [Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[1999]], the amount is $[5600].]

Note to carriers: Use the following text for HSA plans

[per Covered Person	[the greater of $5,100 or the maximum amount permitted under Internal Revenue Code 223]]
[per Covered Family	[the greater of $10,200 or the maximum amount permitted under Internal Revenue Code 223]]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (using Plan C, without Copayment, separate Network and Non-Network Deductibles and Maximum Out of Pockets)**

Calendar Year Cash Deductibles

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

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$1,000, $2,500]
Per Covered Family	[$2,000, $5,000]

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

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$2,000, $5,000]
Per Covered Family	[$4,000, $10,000]

Emergency Room Copayment

(waived if admitted within 24 hours) 100

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

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$5,000
Per Covered Family per Calendar Year	$10,000

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

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$10,000
Per Covered Family per Calendar Year	[$20,000

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

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

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

Physician Visits	[$15, $30, $40 or $50]

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

Per Covered Person	[$1,000, $2,500]
Per Covered Family	[$2,000, $5,000]]

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

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

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

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:
• if treatment, services or supplies are given by a Network Provider 10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider 30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is: 30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Network Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year $5,000
Per Covered Family per Calendar Year $10,000
Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Non-Network Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year $10,000
Per Covered Family per Calendar Year $20,000
Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO**
(using Plan C, with Copayment on specified services, common Deductible and Maximum Out of Pocket)

Copayment
For treatment, services and supplies given by a **Network** Provider
Physician Visits [$15, $30, $40 or $50]

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits
Per Covered Person [$1,000, $2,500]
Per Covered Family [$2,000, $5,000]

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

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

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

• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$5,000
Per Covered Family per Calendar Year	$10,000

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

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) **[PLANS A/50, B, C, D]**
Daily Room and Board Limits

During a Period of Hospital Confinement

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

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

We will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- [Speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Therapeutic Manipulation]
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Nutritional Counseling
- [Certain Prescription Drugs]
- [Exchange of unused Inpatient days for additional Outpatient visits to treat a Non-Biologically Based Mental Illness]

[Plans A/50, B, C, D (Continued)]

We will reduce benefits by 50% with respect to charges for treatment, services and supplies which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

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

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech therapy per Calendar Year	30 visits
Charges for cognitive therapy per Calendar Year	30 visits
Charges for physical therapy per Calendar Year	30 visits
Charges for occupational therapy per Calendar Year	30 visits

Charges for Preventive Care per Calendar Year as follows:
(Not subject to Cash Deductible or Coinsurance)

• for a Covered Person who is a Dependent child for the first year of life	$750
• for all other Covered Persons	$500

Charges for all treatment of Non-Biologically-based Mental Illnesses and Substance Abuse, per Calendar Year

Inpatient Confinement	30 days *
Outpatient Care	20 visits

* [Subject to Our Pre-Approval,] Unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Policy are:
Single Coverage Only.....$

Single and Spouse..... $

Adult and Child(ren) Coverage.....$

Family Coverage.....$]

We have the right to prospectively change any premium rate(s) set forth above at the times and in the manner established by the provision of this Policy entitled "General Provisions."

DEFINITIONS

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

Accredited School means a school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

Alcohol Abuse means abuse of or addiction to alcohol. Alcohol Abuse does not include abuse of or addiction to drugs. Please see the definition of Substance Abuse.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.

We do not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

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

[**Approved Cancer Clinical Trial** means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:
a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.]

Biologically-based Mental Illness means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

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.

We do not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Individual Health Coverage Program, appointed and elected under the laws of New Jersey.

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

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges.

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

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, We pay benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what We limit or exclude.

Covered Person means an Eligible Person who is insured under this Policy. Throughout this Policy, Covered Person is often referred to using "You" and "Your."

Creditable Coverage means, coverage 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 benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation (Please refer to the definition of Public Health Plan in this Policy and note the different meaning of the term with respect to a Federally Defined Eligible Individual and a person who is not a Federally Defined Eligible Individual); a health benefits plan under section 5(e) of the "Peace Corps Act"; Title XXI of the federal Social Security Act (State Children's Health Insurance Program), 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.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, We do not pay for that part of the care which is mainly custodial.

Dependent means Your:
a) Spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an Accredited School. Full-time student status will be as defined by the Accredited School. We can require periodic proof of a Dependent child's status as a full-time student.

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

Your "unmarried Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your step-child,
d) The child of your civil union partner,
e) the child of Your Domestic Partner if the child depends on You for most of his or her support and maintenance, and
f) children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. 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.)

A Dependent does not include a person who is on active duty in the armed forces of any country.

A Dependent does not include 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.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

Developmental Disability or Developmentally Disabled means a severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the Covered Person attains age 19;
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the Covered Person's need for a combination and sequence of special interdisciplinary or generic services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under this Policy if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means Our right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Domestic Partner as used in this Policy and pursuant to P.L. 2003, c. 246, means an individual who is age 18 or older who is the same sex as the Policyholder, and has established a domestic partnership with the Policyholder by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

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

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

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

Effective Date means the date on which coverage begins under this Policy for the Policyholder, or the date coverage begins under this Policy for Your or Your Dependent, as the context in which the term is used suggests.

Eligible Person means a person who is a Resident of New Jersey 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. § 1395 et. seq.) (Medicare).

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

Enrollment Date means with respect to a Federally Defined Eligible Individual means the date the person submits a substantially complete application for coverage. With respect to all other persons, Enrollment Date means the Effective Date of coverage under this Contract for the person.

Experimental or Investigational means We determine a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment 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 primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

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

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

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

1. The American Hospital Formulary Service Drug Information; or
2. 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.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.
In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means 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.

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

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. means a policy, program or plan that provides medical benefits to a group of two or more individuals.

Group Health Plan means 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" (ERISA) (29 U.S.C. §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 means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate or any other similar contract, policy, or plan delivered or issued for delivery in New Jersey, not explicitly excluded from the definition of a health benefits plan. 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 means 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 acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. 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 means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. We will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

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

Illness or Ill means a sickness or disease suffered by a Covered Person or a description of a Covered Person suffering from a sickness or disease.

Injury or Injured means all damage to a Covered Person's body and all complications arising from that damage, or a description of a Covered Person suffering from such damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

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

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and We determine at Our Discretion, that it is:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

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

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

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

[Network] Provider means a Provider which has an agreement [directly or indirectly] with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies. You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

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

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

Non-Biologically-based Mental Illness **means an Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.**

In determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

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

Non- [Network] Provider means a Provider which is not a [Network] Provider.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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

Pharmacy means 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.

Policy means this policy, including the application and any riders, amendments, or endorsements, between You and Us.

Policyholder means the person who purchased this Policy.

Practitioner means a person We are required by law to recognize who:

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

Pre-Approval or Pre-Approved means Our approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before Your Enrollment Date, 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 Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date 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.

Pre-Existing Condition Limitation. With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

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

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

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

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

Public Health Plan means, with respect to a person who is a Federally Defined Eligible Individual, any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

Reasonable and Customary means an amount that is not more than the [lesser of:
• the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area. For charges that are not determined by a negotiated fee schedule, the Covered Person may be billed for the difference between the Reasonable and Customary charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services with Medicare provision includes a distinct definition of Reasonable and Customary.

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with Our policies and procedures that directs a Covered Person to a Facility or Practitioner for health care.]

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

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

Resident means 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, except as stated below; 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, except as stated below.

Exception: For a Federally Defined Eligible Individual, We will not require a person to be present in New Jersey for at least six months of the Calendar Year, but We will require a person to provide proof that his or her primary residence is New Jersey.

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

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

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

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse

Skilled Nursing Facility (see Extended Care Center.)

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:
a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Spouse means an individual: legally married to the Policyholder under the laws of the State of New Jersey; or the Policyholder's Domestic Partner pursuant to P.L. 2003, c. 246; or the Policyholder's civil union partner pursuant to P.L. 2006, c. 103, as well as a person legally joined with the Policyholder in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage.

Substance Abuse means abuse of or addiction to drugs. Substance Abuse does not include abuse of or addiction to alcohol. Please see the definition of Alcohol Abuse.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

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

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

Urgent Care means care for a non-life threatening condition that requires care by a Provider within 24 hours.

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

[You, Your and Yours mean the Policyholder and/or any Covered Person, as the context in which the term is used suggests.**]**

ELIGIBILITY

Types of Coverage

The Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

- **Single Coverage** - coverage under this Policy for only one person.
- **Family Coverage** - coverage under this Policy for You and Your Dependent(s).
- **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 benefit coverage whether or not there is an adult who will be provided coverage.

- **Single and Spouse Coverage** - coverage under this Policy for You and Your Spouse.

Who is Eligible

The Policyholder -You, if You are an Eligible Person.
Spouse - Your Spouse who is an Eligible Person **except:** a Spouse need not be a Resident.
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.

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

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Policy's age limit; b) the child became covered under this Policy or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and c) the child depends on You for most of his or her support and maintenance.

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

The child's coverage ends when Your coverage ends.

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

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.

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 November for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

Adding dependents to this Policy

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 or documentation of domestic partnership or civil union, 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.

Newborn Children - We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:

If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. You must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under this Policy.

If You are not covered for Dependent child coverage on the date the child is born, You must: a) give written notice to enroll the newborn child; and b) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, such coverage will become effective on the first day of the month after the date Your application is received.

Child Dependent - If You have Single or Single and Spouse Coverage and want to add a child Dependent, other than a Newborn Child, 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.

Please note: A Child born to Your Child Dependent is not covered under this Policy unless the Child is eligible to be covered as Your Dependent, as defined.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers. The up-to-date lists will be furnished automatically, without charge.

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

In the case of Urgent Care or an 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 Urgent Care or care and treatment for an 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 Urgent Care or 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] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to 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] Practitioner or Facility will bill him or her directly.

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

What We pay is subject to all the terms of this Policy. You should read Your Policy carefully and keep it available when consulting a Practitioner.

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

If You have any questions after reading Your Policy, You should call Us.

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Provider may be paid] [each time he or she treats a Covered Person ("fee for service"] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a Covered Person desires additional information about how Our primary care physicians or any other Provider in [Carrier's] Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If A Covered Person wants more information about this, contact the Covered Person's physician, chiropractor or podiatrist. If a Covered Person believes he or she is not receiving the information to which he or she is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

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

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. or N.J.A.C. 8:38A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

[CONTINUATION OF CARE

We shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Our Provider network of a Covered Person's PCP and any other Provider from which the Covered Person is currently receiving a course of treatment, as reported to Us. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a determination of fraud, or where Our medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional. In case of pregnancy of a Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a Covered Person who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Covered Person receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with Us.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Us.

If a Covered Person is admitted to a health care Facility on the date this Policy is terminated, We shall continue to provide benefits for the Covered Person until the date the Covered Person is discharged from the facility or exhaustion of the Covered Person's benefits under this Policy, whichever occurs first.

We shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Policy. We shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with Us.

If We refer a Covered Person to a Non-Network provider, the service or supply shall be covered as a Network service or supply. We are fully responsible for payment to the health care professional and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.]

HEALTH BENEFITS INSURANCE

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

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

BENEFIT PROVISION

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

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what We pay is based on all the terms of this Policy.]

[Note to carriers: Use the above deductible text for indemnity plans that are not high deductible health plans that could be used in conjunction with an MSA or an HSA.]

[This Policy has two different Cash Deductibles. One is for treatment, services or supplies given by a Network Provider. The other is for treatment, services or supplies given by a Non-Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Non-Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
[Note to carriers: Use the above deductible text for PPO plans that are not high deductible health plans that could be used in conjunction with an MSA or an HSA.]

[The Cash Deductible:
For Single Coverage Only
Each Calendar Year, You must have Covered Charges that exceed the per Covered Person Cash Deductible before We pay any benefits to You for those charges. The per Covered Person Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by You while insured can be used to meet the Cash Deductible.

Once the per Covered Person 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.]

[Note to carriers: Use the above For Single Coverage Only text for plans that are high deductible health plans that could be used in conjunction with an MSA or an HSA]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once Covered Persons in a family meet the family Cash Deductible in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Policy.]
[Note to carriers, use one of the above text for Family Deductible Limit for an indemnity plan that is not a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

[Family Deductible Limit
This Policy has two different family deductible limits. One is for treatment, services or supplies given by a Network Provider. The other is for treatment services or supplies given by a Non-Network Provider.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Non-Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

What We pay is based on all the terms of this Policy.]
[Note to carriers, use one of the above text for Family Deductible Limit for a PPO plan that is not a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

[Family Deductible Limit:
For Other than Single Coverage
The per Covered Person Cash Deductible is **not** applicable. This Policy has a per Covered Family Cash Deductible which applies in all instances where this Policy provides coverage that is not single only coverage. Once any combination of Covered Persons in a family meets the Per Covered Family Cash Deductible shown in the Schedule, 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.]

Note to carriers: Use the above text for other than single coverage for a plan that is a high deductible health plan that could be used in conjunction with an MSA or an HSA.

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.

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

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use this Maximum Out of Pocket text for a pure indemnity plan that is not high deductible health plans that could be used in conjunction with an MSA or an HSA]

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

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Network Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Network Maximum Out of Pocket has been reached.]

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

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Non-Network Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Non-Network Maximum Out of Pocket has been reached.]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

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

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

[Maximum Out of Pocket:
The Per Covered Person and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Covered Person, the Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance for all covered services and supplies in a Calendar Year. Once the Per Covered Person Maximum Out of Pocket 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 Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance for all covered services and supplies in a Calendar Year. Once the Per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance will be required for members of the covered family for the rest of the Calendar Year.]
[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

Payment Limits
We limit what We will pay for certain types of charges.

Benefits From Other Plans
The benefits We will pay will be affected by a Covered Person's being covered by or eligible for Medicare. Read the provision **Coordination of Benefits and Supplies with Medicare** to see how this works.

[PLAN B]

COVERED CHARGES

This section lists the types of charges We will consider as Covered Charges. But what We will pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

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 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's **Emergency Room Copayment Requirement** section.

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

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, or Extended Care or Rehabilitation Center, he or she must pay a $200 Copayment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Copayment per Calendar Year.

[PLANS A/50, C, D]

COVERED CHARGES
This section lists the types of charges We will consider as Covered Charges. But what We will pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

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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 the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, [subject to this Policy's **Emergency Room Copayment Requirement** section] *[note to carriers: delete this emergency room copayment phrase if the plan is issued in conjunction with an MSA or HSA].*

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

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

[PLANS A/50, B,C,D]

Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a $100.00 Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical condition exists. [Please note that the "911" emergency response system may be used whenever a Covered Person has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

Pre-Admission Testing Charges
We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only covers these tests if: the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

We will reduce benefits by 50% with respect to charges for treatment, services and supplies for Extended Care or Rehabilitation which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Home Health Care Charges
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care. We cover such care furnished to a Covered Person under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Covered Person had been in a Hospital; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered only in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.
b. The services and supplies must be:
   1. ordered by the Covered Person's Practitioner;
   2. included in the home health care plan; and
   3. 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 (no more than three-day) basis.
c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
d. We do not pay for:
   1. services furnished to family members, other than the patient; or
   2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

We will reduce benefits by 50% with respect to charges for treatment, services and supplies for Home Health Care which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

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 a Non-Covered Charge.

Practitioner's Charges for Non-Surgical Care and Treatment
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

We do not pay 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. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.
"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

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

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

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

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 persons who are not Covered Persons.

We will reduce benefits by 50% with respect to charges for treatment, services and supplies for Hospice Care which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Alcohol Abuse
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Treatment for Biologically-based Mental Illness
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Biologically-based Mental Illness the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. We do not pay for Custodial Care, education, or training.

Pregnancy
This Policy pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained below.

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

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of this Policy, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches We cover Medically Necessary and Appropriate replacements or repairs for braces, trusses, orthopedic footwear and crutches.

Blood
Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
We cover Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.]

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) replacements or repairs; or
b) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Policy.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

We will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Food and Food Products for Inherited Metabolic Diseases
We covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the Covered Person's Practitioner.

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

Specialized Infant Formulas
We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Policy] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[Subject to Our Pre-Approval, for certain Prescription Drugs] We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But We only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Hospital Formulary Service Drug Information;
2. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.
Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will We pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.
And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to You before adding a Prescription Drug to the list.

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is a PPO)

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact Us to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after We make a decision regarding Pre-Approval or may choose to purchase the Prescription Drug prior to the decision being made. In either case, the Covered Person must pay for the Prescription Drug when it is dispensed. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

Supplies to Administer Prescription Drugs
We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Policy for treatments that are not Experimental or Investigational.]

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 was not caused, directly or indirectly by biting or chewing; and
b) 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.

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices
We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Policy.

We will reduce benefits by 50% with respect to charges for Prosthetic Devices which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Mammogram Charges
We cover charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female Covered Person, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.

Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, We will cover charges for:
a) a screening fecal occult blood test;
b) flexible sigmoidoscopy,
c) colonoscopy;
d) barium enema;
e) any combination of the services listed in items a – d above; or
f) the most reliable medically recognized screening test available.

We will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

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

Subject to the stated limits, We cover the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

[Subject to Our Pre-Approval,] We cover the Therapy Services listed below, subject to stated limitations:

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

Coverage for Cognitive Rehabilitation Therapy is limited to 30 visits per Calendar Year.

g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.

Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living.

Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.

i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, physical therapy means treatment to develop a Covered Person's physical function.

Coverage for Physical Therapy is limited to 30 visits per Calendar Year.

[We will reduce benefits by 50% with respect to charges for Cognitive Rehabilitation Therapy, Speech Therapy, Occupational Therapy or Physical Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]

j. *Infusion Therapy* - subject to Our Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. We will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any therapy services that are received under the Home Health Care provision, or to services provided while a Covered Person is confined in a Facility.

Preventive Care

We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, lead screening, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:

a) $750 per Covered Person for a Dependent child for the first year of life;
b) $500 per Covered Person for all other Covered Persons.

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.

Newborn Hearing Screening

We cover charges up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We cover charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Vision Screening

We cover vision screening for Dependent children, through age 17, to determine the need for vision correction. The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the Covered Person should undergo a vision examination. Such vision examination is not covered under this Policy.

Therapeutic Manipulation

[Subject to Our Pre-Approval,] We cover therapeutic manipulation up to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge. **[We will reduce benefits by 50% with respect to charges for Therapeutic Manipulation which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]**

Non-Biologically-based Mental Illnesses and Substance Abuse

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse as those terms are defined in this Policy.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker.

The Covered Person must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit coverage for all treatment of Non-Biologically-based Mental Illnesses and Substance Abuse per Calendar Year to:

a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.

Subject to Our Pre-Approval, one or more of any unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits. **We will reduce benefits by 50% with respect to charges for Outpatient visits beyond the initial 20 visits which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**

We do not pay for Custodial Care, education, or training.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Heart-lung
g) Heart Valve
h) Pancreas
i) Intestine
j) Allogeneic Bone Marrow
k) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich]

l) Subject to Our Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **We will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**
l) [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;
m) 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.]

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, this Policy will cover the donor's costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

Surgical Treatment of Morbid Obesity
Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a Covered Person:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether case management may be available and appropriate. See the **Specialty Case Management** section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

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

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, Specialty Case Management or Centers of Excellence Features.]

[UTILIZATION REVIEW FEATURES

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

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

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

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

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

"Regular working day" means [Monday through Friday from 9 am. to 9 pm. Eastern Time.] not including legal holidays.

Grievance Procedure
[Carriers must include the disclosure requirements set forth in N.J.A.C. 8:38A-3.2]

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.
When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;

b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

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

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

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

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

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

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. We reduce what We pay for covered Hospital charges, by 50% if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

[REQUIRED PRE-SURGICAL REVIEW

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

We require a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

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

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

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

Penalties for Non-Compliance
As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

[SPECIALTY CASE MANAGEMENT

Important Notice: No Covered Person is required, in any way, to accept a Specialty Case Management Plan recommended by [DEF].

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

Please note: We have sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or Us to be catastrophic.

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

A Specialty Case Management Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Us].

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

If We, [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon Specialty Case Management treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any Calendar Year maximums.

Exclusion
Specialty Case Management does not include services and supplies that We determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

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

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

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

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

EXCLUSIONS

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

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

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

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

[Broken appointments.]

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

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

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

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

Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Policy.

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

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

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your ***family***: Spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility***

Except as stated in the Newborn Hearing Screening provision, Services or supplies related to ***hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

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

Services or supplies related to ***hypnotism***.

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Except as stated below, ***Illness*** **or** ***Injury***, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

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

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

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services***, except as otherwise stated in this Policy.

Charges for ***missed appointments***.

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

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

Non-prescription drugs or supplies, except
a) insulin needles and syringes and glucose test strips and lancets;
b) colostomy bags, belts and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

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

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

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until 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. If coverage is not issued as a result of the application, the period from the Enrollment Date to the date the application is declined is excluded from the period without 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 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 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 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 Covered Person's Enrollment Date under this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis.

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

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

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

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

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

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

Services or supplies related to ***Routine Foot Care*** except:
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) for which the Covered Person has no legal obligation to reimburse the Provider;
e) provided by or in a government Hospital except as stated below, or unless the services are for treatment:
- of a non-service Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and under military health coverage and who receive care in facilities of the Uniformed Services.
- provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student.

Subject to Our Pre-Approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by Us are Non-Covered Charges.

Travel to obtain medical treatment, drugs or supplies is not covered. In addition, We will not cover treatment, drugs or supplies that are unavailable or illegal in the United States.

Stand-by services required by a Provider.

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

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

Telephone consultations.

Charges for ***third party requests*** for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.

Transplants, except as otherwise listed in this Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

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

Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy.

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

COORDINATION OF BENEFITS AND SERVICES WITH MEDICARE

Purpose Of This Provision

A Member may be covered under this Policy 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. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

Please note: The ONLY circumstance in which a person may be covered under this Policy and under Medicare occurs when a Covered Person is already covered under this Policy and subsequently becomes eligible for Medicare.

DEFINITIONS

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

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under this Policy, or Medicare, except where a statute requires another definition, or as otherwise stated below.

We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by this Policy and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual policy, Medicare is always the Primary Plan and this Policy is always the Secondary Plan. Medicare pays or provides services or supplies first, without taking into consideration the existence of this Policy.

This Policy takes into consideration the benefits provided by Medicare. During each Claim Determination Period, this Policy will pay up to the remaining unpaid allowable expenses, but this Policy will not pay more than it would have paid if it had been the Primary Plan. The method this Policy uses to determine the amount to pay is set forth below in the **"Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

This Policy shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable deductible, coinsurance or copayment. If the Covered Person uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The Covered Person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Covered Person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan
If the Covered Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan
If the Covered Person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

[Primary Plan is an HMO and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under this Policy when services are provided as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Policy;
b) PIP; or
c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits or provide services as if it were primary.

Services this Policy will provide if it is primary to PIP or OSAIC.
If this Policy is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Policy had been primary.

GENERAL PROVISIONS

AMENDMENT

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 Our officers have 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 one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the 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 one of Our officers.
c) if a change is required by Us, 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 one of Our officers.

ASSIGNMENT
No assignment or transfer by the Policyholder of any of the Policyholder's interest under this Policy or by a Covered Person of any of his or her interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error nor programming or systems error by the Policyholder or by Us in keeping any records pertaining to coverage under this Policy will reduce a Covered Person's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Except as described in the **Premium Amounts** section, premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

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

CONFORMITY WITH LAW
Any provision of this Policy which, is in conflict with the laws of the State of New Jersey, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

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 the Policyholder or by a Covered Person covered under this Policy shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

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

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 with the Policyholder.

If to the Policyholder: To the last address provided by the Policyholder on an enrollment or change of address form actually delivered to Us.

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

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by You to Us. They are due on each premium due date. 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 without premium payment during the grace period and this Policy 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.]

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid premiums or claims payment previously made in error.

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. [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.] 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 Member 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 [Premium Rates and Provisions section of the Policy] [Policy's Schedule of Premium Rates]. We have the right to prospectively change Premium rates as of any of these dates:
a) any premium de 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.

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

All statements will be deemed representations and not warranties.

TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

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

We have the right to non-renew this Policy on the Policy Anniversary date following 180 days advance written notice to the Policyholder for the following reasons:

a) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
c) the Board terminates a standard plan or a standard plan option.

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.] [as of the end of the period for which premium has been paid.]
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.] [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 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 individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)

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.

THE CONTRACT
The entire Contract 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.

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

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

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

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after coverage under this Policy ends.

CLAIMS PROVISIONS

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

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

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

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

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

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

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

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

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Repeal and New Rule, R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R 1744(a), 40 N.J.R. 2475(a).

EXHIBIT B

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.

[Carrier] HMO PLAN

INDIVIDUAL HEALTH MAINTENANCE ORGANIZATION (HMO)CONTRACT

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 the cost for services provided. The Contract will be deemed void from the beginning.

EFFECTIVE DATE OF CONTRACT: [January 1, 2005]

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.

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in New Jersey and is governed by the laws thereof.

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

[Secretary President]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Members]

TABLE OF CONTENTS

Section **Page**

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Single Coverage Only	$
Single and Spouse	$
Adult and Child(ren) Coverage	$

Family Coverage. $]

We have the right to prospectively change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled "General Provisions."

SCHEDULE OF SERVICES AND SUPPLIES [Using Copayment]

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS [/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT	[$150, $300, $400, $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [$1,500. $3,000. $4,000. $5,000]/Calendar Year. Unlimited days.
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[$15, $30, $40, $50] Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$100 Copayment/visit/Member (waived if admitted within 24 hours)

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

PRACTITIONER CHARGES FOR SURGERY:	
INPATIENT	$0 Copayment
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit
[FACILITY CHARGES FOR OUTPATIENT SURGERY:	
AMBULATORY SURGERY CENTER	[$15, $30, $40, $50]
HOSPITAL OUTPATIENT DEPARTMENT	[$30, $60, $80, $100]]

[Note to carriers: Use this text if the copay differs based on the setting.]

[FACILITY CHARGES FOR OUTPATIENT SURGERY:	[$15, $30, $40, $50]]

[Note to carriers: Use this text if the copay is the same regardless of the setting.]

HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.
BIRTHING CENTER SERVICES	[$15, $30, $40, $50] Copayment/visit
NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE:	
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	[$150, $300, $400, $500] Copayment/day for a maximum of 5 days per admission.
Maximum Copayment:	[$1,500, $3,000, $4,000, $5,000]/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	[$15, $30, $40, $50] Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	[$15, $30, $40, $50] Copayment/visit.

PRESCRIPTION DRUG	50% Coinsurance
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	[$15, $30, $40, $50] Copayment/visit.
[SPECIALIST SERVICES *[Note to carriers: Use this text if the specialist copay and the PCP copay are the same.]*	[$15, $30, $40, $50] Copayment/visit.]
[SPECIALIST SERVICES *[Note to carriers: Use this item if the specialist copay exceeds the PCP copay.]*	[$30, $50, $60, $70] Copayment/visit]
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	[$15, $30, $40, $50] Copayment/visit.
SKILLED NURSING FACILITY/ EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES	[$15, $30, $40, $50] Copayment/visit.
DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	[$15, $30, $40, $50] Copayment/visit

SCHEDULE OF SERVICES AND SUPPLIES

[Note to Carriers: This schedule illustrates the $15 copayment plan that must be offered by HMO carriers.]

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS AND COINSURANCE AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS /COINSURANCE:**
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$100 Copayment/visit/Member (waived if admitted within 24 hours)

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

PRACTITIONER CHARGES FOR SURGERY:	
INPATIENT	$0 Copayment
OUTPATIENT	$15 Copayment/visit
FACILITY CHARGES FOR OUTPATIENT SURGERY:	$15
HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.
BIRTHING CENTER SERVICES	$15 Copayment/visit

NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE:	
OUTPATIENT	$15 Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment: $1,500/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	$15 Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.]
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SKILLED NURSING FACILITY/ EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	$15 Copayment/visit

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

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

COPAYMENT	
For Primary Care Physician and Preventive Care Visits	[$15, $30, $40, $50] per visit
Maternity (pre-natal care)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment/initial visit.
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER CALENDAR YEAR	
•For Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•for all other Covered Services and Supplies	
•Per Covered Person	[$1,000, $2,500]
• Per Covered Family	[$2,000, $5,000.]
COINSURANCE	
PRESCRIPTION DRUG	50% Coinsurance
For all services and supplies to which a Copayment does not apply	[10% - 50%, in 10% increments]
For all services and supplies to which a Copayment applies	None
EMERGENCY ROOM COPAYMENT	$100 Copayment/visit/Member (waived if admitted within 24 hours).

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

MAXIMUM OUT OF POCKET
Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance or copayments paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance or copayments must continue to be paid even after the Maximum Out of Pocket has been reached.

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

•Per Member per Calendar Year	[$5,000]
•Per Family per Calendar Year	[$10,000.]

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

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Non-Biologically-Based Mental Illness and Substance Abuse	
•Outpatient Visits	20 visits per Calendar Year.
•Inpatient Confinement	30 days per calendar year

[Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.]

Speech Therapy	30 visits per Calendar Year
Cognitive Rehabilitation Therapy	30 visits per Calendar Year
Physical Therapy	30 visits per Calendar Year
Occupational Therapy	30 visits per Calendar Year
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval

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

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

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies are provided.

ACCREDITED SCHOOL. A school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

ALCOHOL ABUSE. Abuse of or addiction to alcohol. Alcohol Abuse does not include abuse of or addiction to drugs. Please see the definition of Substance Abuse.

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

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

b) have operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for ambulatory care; or
b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

[APPROVED CANCER CLINICAL TRIAL. A scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:
a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training
e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.]

[ASSOCIATED MEDICAL GROUP. Any medical group with which We contract directly to provide Covered Services and Supplies to [Members] including the [XYZ Group].]

BIOLOGICALLY BASED MENTAL ILLNESS. A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

BOARD. The 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 health care treatment.]

[CASH DEDUCTIBLE. A fixed dollar amount that a Member must pay before [Carrier] provides the [Member] with coverage for Covered Services or Supplies.]

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 a [Member]. Coinsurance does not include Copayments [or Cash Deductible].]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and [Carrier].

CONTRACTHOLDER. The person who purchased this Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies. **NOTE:** The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Coinsurance [or Cash Deductible].

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract.

Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. Coverage 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 benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation (Please refer to the definition of Public Health Plan in this Contract and note the different meaning of the term with respect to a Federally Defined Eligible Individual and a person who is not a Federally Defined Eligible Individual); a health benefits plan under section 5(e) of the "Peace Corps Act"; Title XXI of the federal Social Security Act (State Children's Health Insurance Program), 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[Member] meet[Member]'s routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other recognized Facility, We do not provide for that part of the care which is mainly custodial.

DEPENDENT.
Your:
a) Spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an Accredited School. Full-time student status will be as defined by the Accredited School. We can require periodic proof of a Dependent child's status as a full-time student.

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

Your "unmarried Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your step-child,
d) the child of Your civil union partner,
e) the child of Your Domestic Partner if the child depends on You for most of his or her support and maintenance, and
f) children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. 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.)

A Dependent does not include a person who is on active duty in the armed forces of any country.

A Dependent does not include 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.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the [Member] attains age 19;
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the [Member's] need for a combination and sequence of special interdisciplinary or generic services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION / DETERMINATION / DETERMINE. Our right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DOMESTIC PARTNER. As used in this Policy and pursuant to P.L. 2003, c. 246 means an individual who is age 18 or older who is the same sex as the Policyholder, and has established a domestic partnership with the Policyholder by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

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

EFFECTIVE DATE. The date on which coverage begins under this Contract for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident of New Jersey 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. § 1395 et. seq.) (Medicare).

EMERGENCY. A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an Emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

ENROLLMENT DATE. With respect to a Federally Defined Eligible Individual means the date the person submits a substantially complete application for coverage. With respect to all other persons, Enrollment Date means the Effective Date of coverage under this Contract for the person.

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies which We Determine are:

a) not of proven benefit for the particular diagnosis or treatment of a [Member]'s particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member]'s particular condition; or

c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member]'s particular condition.

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

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

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

I. The American Hospital Formulary Service Drug Information; or
II. 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.

EXTENDED CARE CENTER. See Skilled Nursing Facility.

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.

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.

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" (ERISA) (29 U.S.C. § 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 or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate or any other similar contract, policy, or plan delivered or issued for delivery in New Jersey not explicitly excluded from the definition of a health benefits plan. 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 CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] [] Providers provide Covered Services and Supplies to [Members].]

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 acts 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. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

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

ILLNESS or ILL. A sickness or disease suffered by a[Member] or a description of a [Member] suffering from a sickness or a disease.

INJURY or INJURED. Damage to a [Member]'s body, and all complications arising from that damage or a description of a [Member] suffering from such damage.

INPATIENT. [Member] if physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We [or the Care Manager] Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a[Member]'s convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, the fact that a Non-Network Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

[MEMBER]. An eligible person who is covered under this Contract.

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies. You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

In determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in this Contract.

NON- [NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

OUTPATIENT. [Member], if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's license or certificate.

PRE-APPROVAL or PRE-APPROVED. Specific direction or instruction from a Network Practitioner or from Us in conformance with Our policies and procedures that authorizes a [Member] to use a Provider for health care services or supplies.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your Enrollment Date, 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 Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date 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.

PRE-EXISTING CONDITION LIMITATION. With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:

a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration:
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:

- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.
In no event will We pay for:

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

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member]'s Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROVIDER. A recognized Facility or Practitioner of health care.

PUBLIC HEALTH PLAN., With respect to a person who is a Federally Defined Eligible Individual, means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
• the] usual or customary charge for the service or supply as determined by Us, based on a standard approved by the Board[: or
[• the negotiated fee schedule.]

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

Please note: The Coordination of Benefits and Services with Medicare provision includes a distinct definition of Reasonable and Customary.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that directs a [Member] to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

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

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

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, except as stated below; 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, except as stated below.

Exception: For a Federally Defined Eligible Individual, We will not require a person to be present in New Jersey for at least six months of the Calendar Year, but We will require a person to provide proof that his or her primary residence is New Jersey.

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

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females)].

SPOUSE. An individual: legally married to the Contractholder under the laws of the State of New Jersey; or the Contractholder's Domestic Partner pursuant to P.L. 2003, c. 246; or the Contractholder's civil union partner pursuant to P.L. 2006, c. 103, as well as a person legally joined with the Contractholder in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage.

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does not include abuse of or addiction to alcohol. Please see the definition of Alcohol Abuse.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SURGERY.
a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care;
d) any of the procedures designated by the Current Procedural Terminology Codes as surgery.

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

URGENT CARE. Care for a non-life threatening condition that requires care by a Provider within 24 hours.

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder or any Member, as the context in which the term is used suggests.]

ELIGIBILITY

Types of Coverage

The Contractholder who completes an application for coverage may elect one of the types of coverage listed below:

- **Single Coverage** - coverage under this Contract for only one person.
- **Family Coverage** - coverage under this Contract for You and Your Dependent(s).
- **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.

- **Single and Spouse Coverage** - coverage under this Contract for You and Your Spouse.

Who is Eligible

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.
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.
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.

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

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Contract's age limit; b) the child became covered under this Contract or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and c) the child depends on You for most of his or her support and maintenance.

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

The child's coverage ends when Your coverage ends.

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

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.

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 November for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

Adding dependents to this contract

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 or documentation of domestic partnership or civil union, 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.

Newborn Children - We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:

If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. You must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under this Contract.

If You are not covered for Dependent child coverage on the date the child is born, You must: a) give written notice to enroll the newborn child; and b) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, such coverage will become effective on the first day of the month after the date Your application is received.

Child Dependent - If You have Single or Single and Spouse Coverage and want to add a child Dependent, other than a Newborn Child, 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.

Please note: A Child born to Your Child Dependent is not covered under this Contract unless the Child is eligible to be covered as Your Dependent, as defined.

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [a Biologically-based Mental Illness, a Non-Biologically-based Mental Illness, Substance Abuse, or Alcohol Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When You first obtain this coverage You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Physician from Our [Physician or Practitioners] Directory].

[For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

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 his or her Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES
In the event that due to circumstances not within Our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Our [Network] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide

services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event. In the event We cannot provide or arrange for any services for three or more days We will refund premium for that period for which no services are available.

REFERRAL FORMS
A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Physician.

Except in the case of an Emergency, a [Member] will not be eligible for any services provided by anyone other than a [Member's] Primary Care Physician (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

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 [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner 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 Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding the position of the [Network] Practitioner(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 Appeals Procedure, to terminate his or her coverage under this Contract. 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 [Network] Practitioner 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.

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive or the [Member] abuses the system, including but not limited to: theft, damage to [Our] [Network Provider's] property, and consistent failure to keep scheduled appointments.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any identification card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes material information that is either incorrect or incomplete in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
e) **Misconduct:** The [Member] abuses the system through forgery of drug prescriptions.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeal Procedures We establish.

REPORTS AND RECORDS
We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, You, for Yourself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to

Us all facts and information pertaining to the care, treatment and physical condition of the [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

LIMITATION ON SERVICES

Except in cases of Emergency, services are available only from Network Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a [Member] from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service"] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member], the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE

NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

CONTINUATION OF CARE

We shall provide written notice to each [Member] at least 30 business days prior to the termination or withdrawal from Our Provider Network of a [Member's] PCP and any other Provider from which the [Member] is currently receiving a course of treatment, as reported to Us. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a determination of fraud, or where Our medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the [Member] to continue treatment with the terminated health care professional.

In case of pregnancy of a [Member], coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the [Member], up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a [Member] who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a [Member] who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a [Member] receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with Us.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Us.

If a [Member] is admitted to a health care Facility on the date this Contract is terminated, We shall continue to provide benefits for the [Member] until the date the [Member] is discharged from the Facility or exhaustion of the [Member's] benefits under this Contract, whichever occurs first.

We shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a [Member's] continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Contract. We shall not be liable for any inappropriate treatment provided to a [Member] by a health care professional who is no longer employed by or under contract with Us

If We refer a [Member] to a [Non-Network] provider, the service or supply shall be covered as a [Network] service or supply. We are fully responsible for payment to the health care professional and the [Member's] liability shall be limited to any applicable [Network] Copayment, or Coinsurance for the service or supply.

[COVERAGE PROVISION

[The Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[Family Deductible Limit
This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once [Members] in a family meet the family Cash Deductible in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Deductible Credit: For the first Calendar Year of this Contract, a [Member] will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Contract provided there has been no lapse in coverage between the previous coverage and this Contract.

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.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year.]

Once Members in a family meet the family Maximum Out of Pocket, no other Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Exception: Coinsurance or copayments paid for covered prescription drugs do not count toward the Maximum Out of Pocket. Such coinsurance or copayments must continue to be paid even after the Maximum Out of Pocket has been reached.

[Note to carriers: The Coverage Provision section is only to be included in plans where coverage is subject to deductible and coinsurance.]

COVERED SERVICES & SUPPLIES

[Members] are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable copayments [Cash Deductible,] [or Coinsurance] as stated in the applicable Schedule of Services and Supplies and subject to the terms, conditions and limitations of this Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior written Referral by a [Member]'s Primary Care Physician [or Health Center] [or the Care Manager]:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Home visits** by a [Member]'s Primary Care Physician.
3. **Periodic health examinations** to include:
   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 a [Member]'s employment).
4. **Diagnostic Services**.
5. **Casts and dressings.**
6. **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a [Member]'s Primary Care Physician and Pre-Approved by Us.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury, as stated in the Dental Care and Treatment provision of this Contract.
9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Physician and arranged through Us.
10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** including **contraceptives which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider.
    [A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the [Member's] Network Provider.
    A supply will be considered to be furnished at the time the Prescription Drug is received.]

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You. We will give at least 30 days advance written notice to You before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Member must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of this Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in this Contract.]

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
    a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
    b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract. and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

a) a screening fecal occult blood test;
b) flexible sigmoidoscopy,
c) colonoscopy;
d) barium enema;
e) any combination of the services listed in items a – d above; or
f) the most reliable medically recognized screening test available.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:

a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19) **Newborn Hearing Screening** We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

20) **Mammogram Screening** We will provide coverage for:

a) one baseline mammogram for a female [Member], age 35 - 39
b) one mammogram, every year, for a female [Member] age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior written Referral by a [Member]'s Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:

1. Semi-private room and board accommodations

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 the [Member], in consultation with the Network Provider, determine that a shorter length of stay is Medically Necessary and 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) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

2. Private accommodations [will be provided only when Pre-Approved by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; 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. We also cover treatment of the physical complications of mastectomy, including lymphedemas.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart, heart-lung, heart valve, Pancreas and Intestines.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]
25. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND NON-BIOLOGICALLY-BASED MENTAL ILLNESSES.** The following Services are covered when rendered by a Network Provider at Provider's office or at a Network Substance Abuse Center [or Health Center] upon prior written referral by a [Member]'s Primary Care Physician [or the Care Manager]. This section does *not* address coverage for a Biologically-based Mental Illness.

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member]'s Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Non-Biologically-based Mental Illnesses. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member]'s Primary Care Physician [or the Care Manager], for up to sixty (60) more outpatient visits by exchanging one or more of the inpatient hospital days described in paragraph 2 below where each exchanged inpatient day provides two outpatient visits.

2. **Inpatient Hospital Care.** [Members] are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the Substance Abuse, referral services for Substance Abuse, and Non-Biologically-based Mental Illnesses. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan developed by a Network Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

(e) **BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS OR ALCOHOL ABUSE.** We cover treatment of a Biologically-based Mental Illness or Alcohol Abuse the same way We would for any other illness, if such treatment is prescribed by a Network Provider upon prior written referral by a [Member]'s Primary Care Physician [or the Care Manager]. We do not pay for Custodial care, education or training.

(f) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior written Referral by a [Member]'s Primary Care Physician in the event of an Emergency as Determined by Us.

1. A [Member]'s Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:

a. Our review Determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
c. We and the [Member]'s Primary Care Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event a [Member] is Hospitalized in a Non-Network Facility, coverage will only be provided until the [Member] is medically able to travel or to be transported to a Network Facility. If the [Member] elects to continue treatment with Non-Network Providers. We shall have no responsibility for payment beyond the date the [Member] is Determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written Referral to a Network Provider.

4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the [Member] shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a [Member] is admitted as an Inpatient to the Hospital as a result of the Emergency.
6. Coverage for Emergency and Urgent Care include coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provides coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Emergency medical condition exists. . [Please note that the "911" Emergency response system may be used whenever a Covered person has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

(g) **THERAPY SERVICES.** The following Services are covered when rendered by a Network Provider upon prior written Referral by a [Member]'s Primary Care Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

Coverage for Cognitive Rehabilitation Therapy is limited to 30 visits per Calendar Year.

g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a [Member] who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.

Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a [Member] who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a [Member's] ability to perform the ordinary tasks of daily living.

Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.

i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a [Member] who has been diagnosed with a biologically-based mental illness, physical therapy means treatment to develop a [Member's] physical function.

Coverage for Physical Therapy is limited to 30 visits per Calendar Year.

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

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any Therapy Services that are received under the Home Health Care provision.

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Physician. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;
8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the [Member] had been in a Hospital; and
9) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Contract and to the following conditions:

a. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.
b. The services and supplies must be:
    1. ordered by the [Member's] Practitioner;
    2. included in the home health care plan: and
    3. 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 (no more than three-day) basis.
c. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
e. We do not pay for:
    1. services furnished to family members, other than the patient; or
    2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

We **only** cover services 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 this **Home Health Care** section. Any other services for private duty nursing care are Non-Covered Services.

(j) **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member]'s Primary Care Physician. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(k) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury was not caused, directly or indirectly by biting or chewing; and

2) 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.

For a [Member] who is severely disabled or who is a Child under age 6, We cover:

a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

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

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

(n) **[Cancer Clinical Trial** We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Member during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Member receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Member to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Contract for treatments that are not Experimental or Investigational.]

(o) **Surgical Treatment of Morbid Obesity** Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

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

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

Blood or blood plasma which is replaced by or for a [Member].

[Broken appointments.]

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

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in this Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes

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

Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Contract.

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

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

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your **family**: Spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility.**

Except as otherwise stated in this Contract, services or supplies related to **hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

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

Services or supplies related to **hypnotism**.

Services or supplies necessary because the [Member] engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Except as stated below, Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

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

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

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

Charges for **missed appointments**.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in this Contract for food and food products for inherited metabolic diseases.

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

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

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until 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. If coverage is not issued as a result of the application, the period from the Enrollment Date to the date the application is declined is excluded from the period without 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 Member's Enrollment Date under the Contract, measured from the last date the Creditable Coverage was in force on a premium paying basis.

Any service provided without prior written Referral by the [Member]'s **Primary Care Physician,** except as specified in this Contract.

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

In the event of an Emergency, the amount of any charge which is greater than the amount We Determine to be the **reasonable and customary charge**.

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

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

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;
d) for which the Member has no legal obligation to reimburse the Provider;
e) provided by or in a Government Hospital except as stated below, or unless the services are for treatment:
   - of a non-service Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;

   Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Contract and under military health coverage and who receive care in facilities of the Uniformed Services.

Stand-by services required by a Provider.

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

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

Telephone consultations.

Charges for **third party requests** for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

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

Weight reduction or control, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Contract.

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

COORDINATION OF BENEFITS AND SERVICES WITH MEDICARE

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. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the [Member] is covered.

Please note: The ONLY circumstance in which a person may be covered under this Contract and under Medicare occurs when a Member is already covered under this Contract and subsequently becomes eligible for Medicare.

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

Allowable Expense: The charge for any health care service, supply or other item of expense for which the [Member] is liable when the health care service, supply or other item of expense is covered at least in part under this Contract, or Medicare, except where a statute requires another definition, or as otherwise stated below.

We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a [Member] is covered by this [Contract] and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

PRIMARY AND SECONDARY PLAN
We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual Contract, Medicare is always the Primary Plan and this Contract is always the Secondary Plan. Medicare pays or provides services or supplies first, without taking into consideration the existence of this Contract.

This Contract takes into consideration the benefits provided by Medicare. During each Claim Determination Period, this Contract will pay up to the remaining unpaid allowable expenses, but this Contract will not pay more than it would have paid if it had been the Primary Plan. The method this Contract uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

This Contract shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the [Member] may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the [Member] may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the [Member] uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the [Member] shall not exceed the fee schedule of the Primary Plan. In no event shall the [Member] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The [Member] shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the [Member] has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the [Member] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan
If the [Member] receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan
If the [Member] receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The [Member] shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

[Primary Plan is an HMO and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under this Contract when services are provided as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

AMENDMENT

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT
No assignment or transfer by the Contractholder of any of the Contractholder's interest under this Contract or by a [Member] of any of his or her interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error nor programming or systems error by the Contractholder or by Us in keeping any records pertaining to coverage under this Contract will reduce a [Member]'s Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Except as described in the **Premium Amounts** section, premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

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

CONFORMITY WITH LAW
Any provision of this Contract which, is in conflict with the laws of the State of New Jersey, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a [Member]: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any claims payment previously made to You in error.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

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.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by You to Us. They are due on each premium due date. 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.]

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. [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.] 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 prospectively change Premium rates as of any of these dates:
any premium due date;
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;

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.

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

All statements will be deemed representations and not warranties.

TERM OF THE CONTRACT - RENEWAL PRIVILEGE – TERMINATION

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

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

We have the right to non-renew this Contract on the Contract Anniversary date following 180 days advance written notice to the Contractholder for the following reasons:
a) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
c) the Board terminates a standard plan or a standard plan option.

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) [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.]

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.

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.

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

CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

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

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after coverage under this Contract ends.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit F and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit B, repealed.
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).

EXHIBIT C

EXPLANATION OF BRACKETS

Plans A/50 through D
(Appendix Exhibit A)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
b) Some areas of variability are noted with brief italicized explanations within the text. Examples include: use of high deductible health plan text and specialist copay.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are determined by the delivery system (i.e., indemnity or PPO)

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO plans, explicit guidance is set forth in item 15 below.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
3. Deductible, and Co-Payments, as offered by the carrier, may be elected by the Policyholder, subject to the availability specified in regulation.
4. There are sample PPO schedule pages. There are corresponding provisions in the benefit provisions.
5. The list of services and supplies for which pre-approval is required includes some new items, included in brackets: specified therapies, therapeutic manipulation, exchange of non-biologically based mental illness inpatient days and prescription drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.
6. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
7. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option delivery system.
8. The text describing provider compensation in the PPO section contains a number of bracketed words and phrases. Include the words and phrases that describe the arrangement carrier has with network providers.
9. The continuation of care text must be included in all plans that use networks.
10. The treatment of hemophilia provision includes variable text that would only be included in PPO plans.
11. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
12. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
13. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy.
14. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
15. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:
    a. The policy and certificate documents contain "SAMPLE" schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:20-3.1(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use. ($15, $30, $40 or $50)
    b. Include the specific page of text describing the PPO mechanism, with specification of the name of the network or provider organization.
16. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.

17. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

HMO Contract
(Appendix Exhibit B)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does ***not*** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], and [ABC].
b) Some areas of variability are noted with brief explanations within the text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract and Evidence of Coverage forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. Co-Payments may be elected by the Contractholder, subject to the availability specified in regulation.
4. Deductible, coinsurance and maximum out of pocket provisions may be included. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
5. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include.
6. OB/GYNs can be considered Primary Care Physicians.
7. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
8. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
9. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Repeal and New Rule, R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

EXHIBIT D

[Carrier]
AMENDMENT

[Policyholder]

[Effective date]
[

]
This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any of the terms of the [Policy].
[Carrier shall insert its standard amendment closure and signature blocks.]

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).
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See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
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See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
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See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit S and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit D, repealed.

EXHIBIT E

CERTIFICATION OF COMPLIANCE WITH INDIVIDUAL HEALTH COVERAGE PLANS

In accordance with N.J.A.C. 11:20-3.2, submit this form, upon entry into the market and by March 1 of every year, to the IHC Board at the address specified at N.J.A.C. 11:20-2.1. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: _____ NAIC #: _____
Respondent Information:
Name: _____ Title: _____
Address: _____
_____
Telephone: _____ FAX: _____ Email address: _____

2. COMPLIANCE

Check the appropriate response(s).
_____(a) Plans A/50, B, C, and D comply fully with the IHC Board's individual health benefits plans forms and Explanation of Brackets set forth at Exhibits A and C of the Appendix to N.J.A.C. 11:20.
_____(b) The HMO Plan complies fully with the IHC Board's individual health benefits plans form and Explanation of Brackets set forth at Exhibits B and C of the Appendix to N.J.A.C. 11:20.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section. Attach additional pages as necessary.

(a) Plans A/50 through D

On the attached worksheet for Plans A/50 through D, provide information regarding all of the plans carrier makes available using Plans A/50 through D. Add or delete rows under each plan designation, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.
Delivery System: Identify whether each plan is sold as Traditional Indemnity (Designate as Indem) or Preferred Provider Organization (Designate as PPO).
Copayment: For all plans that use a copayment, specify the applicable copayments for Physician Visits, Maternity, specialist and outpatient surgery.
Deductible: List the available deductible options. Indemnity plans as well as PPO plans that use a common deductible should list that amount under the Indemnity/Common column. PPO plans that use separate deductible for network and non-network services should list such dollar amounts under the appropriate column headings
Coinsurance: List the available policyholder coinsurance options as specific percentages. Indemnity plans as well as PPO plans that use a common coinsurance should list that amount under the Indemnity/Common column. PPO plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.
1. Do contracts provide for direct payment to health care practitioners without assignment? ☐Yes ☐No
2. Specify how coverage for autologous bone marrow transplants is offered.
☐Plan benefit; or ☐Rider benefit

(b) HMO Plans

On the attached worksheet for HMO Plans, provide information regarding all of the plans carrier makes available using the HMO plan. Add or delete rows under each plan type, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.
Copayment: Specify the applicable copayments for Physician Visits, Maternity, specialist visit and outpatient surgery.
Deductible: List the available deductible options as specific amounts
Coinsurance: List the available policyholder coinsurance options as specific percentages.

1. Specify how coverage for autologous bone marrow transplants is offered.
☐Plan benefit; or ☐Rider benefit

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.

_____ _____
Signature Title

_____ _____
Printed Name Date

Carrier Name:

Plans A/50 through D											
Plan	Delivery System	Copayment				Deductible			Coinsurance		
		Physician Visit	Maternity	Specialist	Outpatient Surgery	Indemnity or Common	Network	Non-Network	Indemnity or Common	Network	Non-Network
A/50											
B											
C											
D											

HMO Plans					
Copayment				Deductible	Coinsurance
Physician Visit	Maternity	Specialist	Outpatient Surgery		

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

EXHIBIT F

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 BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN
As required by P.L. 2001, c. 368

EFFECTIVE DATE OF [POLICY]: [January 1, 2005]

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.

In consideration of the application for this [Policy] and of the payment of premiums as stated herein, We agree to pay benefits in accordance with and subject to the terms of this [Policy]. This [Policy] is delivered in New Jersey and is governed by the laws thereof.

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

THIS POLICY IS A LIMITED BENEFITS PLAN AND DOES **NOT** PROVIDE COMPREHENSIVE MAJOR MEDICAL COVERAGE

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Covered Persons]]

TABLE OF CONTENTS

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].

ACCREDITED SCHOOL. A school approved by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

ALCOHOL ABUSE. Abuse of or addiction to alcohol. Alcohol Abuse does **not** include abuse of or addiction to drugs. Please see the definition of Substance Abuse.

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

ANNIVERSARY DATE. The date which is one year from the Effective Date of this [Policy] and each succeeding yearly date thereafter.

BIOLOGICALLY-BASED MENTAL ILLNESS. A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period.

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.] *[Note to carriers: Include if issued as a managed care plan that uses care managers.]*

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this [Policy] pays any benefits for such charges. The Deductible is shown in the Coverage Schedule. The Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the "Cash Deductible" provision of this [Policy] for details.

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, as shown in the Coverage Schedule. Coinsurance does **not** include Cash Deductibles, Copayments or Non-Covered Charges.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. [You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.]

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

[COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in 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 wellness 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.] *[Note to carriers: Include if issued as a non HMO-based plan. HMO based plans should use the Covered Services or Supplies text that follows.]*

COVERED PERSON. An Eligible Person who is insured under this [Policy]. Throughout this [Policy], Covered Person is often referred to using "You" and "Your."

[COVERED SERVICES OR SUPPLIES. The types of services and supplies described in 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 wellness 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

Furnished within the framework of generally accepted methods of medical management currently used in the United States.] *[Note to carriers: Include if issued as an HMO-based plan. Non-HMO based plans should use the Covered Services or Supplies text that appears above.]*

Read the entire Contract to find out what We limit or exclude. *[Note to carriers: Include if issued as an HMO-based plan.]*

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 benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation (Please refer to the definition of Public Health Plan in this Policy and note the different meaning of the term with respect to a Federally Defined Eligible Individual and a person who is not a Federally Defined Eligible Individual); 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.

Even if you are in a Hospital or other recognized facility, We do not pay for that part of the care which is mainly custodial.

DEPENDENT. Your:
a) Spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an Accredited School. Full-time student status will be as defined by the Accredited School. We can require periodic proof of a Dependent child's status as a full-time student.

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

Your "unmarried Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your step-child,
d) The child of Your civil union partner,
e) the child of Your Domestic Partner if the child depends on You for most of his or her support and maintenance, and
f) children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. 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.)

A Dependent does not include a person who is on active duty in the armed forces of any country.

A Dependent does not include 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.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

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 Wellness benefit provision of this [Policy], Diagnostic Services are not covered under this [Policy] if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION/DETERMINE. Our right to make a decision or determination. Our decision will be applied in a reasonable and non-discriminatory manner.

DOMESTIC PARTNER. As used in this [Policy] and pursuant to P.L. 2003, c. 246, means an individual who is age 18 or older who is the same sex as the [Policyholder], and has established a domestic partnership with the [Policyholder] by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

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 the [Policyholder], or the date coverage begins under this [Policy] for Your or Your Dependent, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident of New Jersey 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. § 1395 et. seq.) (Medicare).

EMERGENCY. A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

ENROLLMENT DATE. With respect to a Federally Defined Eligible Individual means the date the person submits a substantially complete application for coverage. With respect to all other persons, Enrollment Date means the Effective Date of coverage under this Contract for the person.

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 treatment 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 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.

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. § 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 or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate or any other similar contract, policy, or plan delivered or issued for delivery in New Jersey, not explicitly excluded from the definition of a health benefits plan. 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.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally Injured.

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 either:
a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, 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.

ILLNESS (OR ILL). A sickness or disease suffered by You or a description of You suffering from a sickness or disease.

INJURY (OR INJURED.) All damage to Your Body and all complications arising from that damage or a description of You suffering from such damage.

INPATIENT. A Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, or Injury;
c) in accordance with generally accepted medical practice;
d) not for Your convenience;
e) the most appropriate level of medical care that You need; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

MEDICAID. 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.

[[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.] You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.] *[Note to carriers: Include if issued as a plan with network or participating providers.]*

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

In Determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

NON-COVERED CHARGES. 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 Charges. Utilization Review Penalties are also Non-Covered Charges.

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.] *[Note to carriers: Include if issued as a plan with network or participating providers.]*

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.

OUTPATIENT. A person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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.

[POLICY]. This agreement, [the [Policy] Coverage Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

[POLICY]HOLDER. The person who purchased this [Policy].

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.

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 Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date is also a Pre-Existing Condition. However, complications of 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.

PRE-EXISTING CONDITION LIMITATION. With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

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.

[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.] *[Note to carriers: Include if issued as a managed care plan that uses a PCP.]*

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROVIDER. A recognized Facility or Practitioner of health care in accordance with the terms of this [Policy].

PUBLIC HEALTH PLAN. With respect to a person who is a Federally Defined Eligible Individual means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

[REASONABLE AND CUSTOMARY. An amount that is not more than the lesser of:
a) The reasonable and customary charge for the service or supply as set forth in the Prevailing HealthCare Charges System (PHCS) data using the 80th percentile; or
b) The negotiated fee, if any, between [Carrier] and the Provider for the service or supply.]
[Note to carriers: Carriers that issue this plan as an HMO may omit this definition.]

[**REFERRAL.** Specific direction or instructions from Your Primary Care Physician [or care manager] in conformance with Our policies and procedures that directs a Covered Person to a Facility or Practitioner for health care.]
[Note to carriers: Carriers that issue this plan as an HMO should include this definition.]

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people.

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, except as stated below.

Exception: For a Federally Defined Eligible Individual, We will not require a person to be present in New Jersey for at least six months of the Calendar Year, but We will require a person to provide proof that his or her primary residence is New Jersey.

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 FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital.

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.] *[Note to carriers: Include if issued as a managed care plan that uses these terms.]*

SPOUSE. An individual: legally married to the [Policyholder] under the laws of the State of New Jersey; or the [Policyholder's] Domestic Partner pursuant to P.L. 2003, c. 246; or the [Policyholder's] civil union partner pursuant to P.L. 2006, c. 103, as well as a person legally joined with the [Policyholder] in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage.

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

SUBSTANCE ABUSE CENTER. 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 either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

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 Current Procedural Terminology 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 Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare.

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.

URGENT CARE. Care for a non-life threatening condition that requires care by a Provider within 24 hours.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The [Policy]holder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A [Policy]holder 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 whom there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
d) **Single and Spouse Coverage** - coverage under this [Policy] for You and Your Spouse.

WHO IS ELIGIBLE

a) **The [Policy]holder** - You, if You are an Eligible Person.
b) **Spouse** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident;.
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.

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

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Policy's age limit; b) the child became covered under this Policy or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and c) the child depends on You for most of his or her support and maintenance.

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

The child's coverage ends when Your coverage ends.

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.

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 [Policy]** - You and/or Your Dependents are eligible for coverage under this [Policy] if this [Policy] replaces another individual [Policy] under which You and/or Your Dependents are covered. You may request termination of the replaced individual [Policy] 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 November, 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 or documentation of domestic partnership or civil union, 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 of the month following the date Your application is received.

b) **Newborn Children -** We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:

If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. You must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under this Policy.

If You are not covered for Dependent child coverage on the date the child is born, You must: a) give written notice to enroll the newborn child; and b) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, such coverage will become effective on the first day of the month after the date Your application is received.

c) **Child Dependent -** If You have Single or Husband and Wife Coverage and want to add a Child Dependent, other than a Newborn Child, 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.

Please note: A Child born to Your Child Dependent is not covered under this [Policy] unless the Child is eligible to be covered as Your Dependent, as defined.

COVERAGE SCHEDULE

Copayments:

• Hospital Confinement	$500 per Covered Person per Period of Confinement
• Inpatient Care for Biologically Based Mental Illness	$500 per Covered person per Period of Confinement
• Outpatient and Ambulatory Surgery	$250 per Covered Person per Surgery
• Emergency Room Services	$100 per Covered Person per Visit
• Outpatient Physical Therapy	$20 per Covered Person per Visit
• All other Covered Services and Supplies	None

[**NOTE**: You may be required to pay an amount in excess of the above Copayments if the Provider's bill exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: This text should be included when there is a possibility of balance billing.]*

Deductible:

• Wellness benefit	$50 per Covered Person per Calendar Year
• All other Covered Services and Supplies	None

[Policy]holder Coinsurance:

• Alcohol and Substance Abuse Inpatient and Outpatient For Inpatient Care, Coinsurance applies *after* the payment of the Copayment	30%
• Biologically Based Mental Illness Outpatient Care	30%
• Wellness Benefit Coinsurance applies *after* the payment of the Deductible	20%
• All other Covered Services and Supplies	NONE

Coverage Limits:

• Hospital Confinement	90 days per Covered Person per Calendar Year
• Biologically Based Mental Illness	
Inpatient Care	90 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per Calendar Year
• Alcohol and Substance Abuse	
Inpatient Care	30 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per Calendar Year
• Physical Therapy (Outpatient)	30 visits per Covered Person per Calendar Year
• All Other	Unlimited

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.

Maximum Benefits

• Out-of Hospital diagnostic tests	$500 per Covered Person per Calendar Year
• Wellness benefit	$600 per Covered Person per Calendar Year
• Practitioner visits for injury or sickness	$700 per Covered person per Calendar Year
• All other services and supplies:	Unlimited

PREMIUM RATES AND PROVISIONS

PREMIUM RATES
[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.	[$]
For Single and Spouse Coverage.	[$]

We have the right to prospectively change the Premium rate set forth in this [Policy].

[CONTINUATION OF CARE

We shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Our Provider network of a Covered Person's [PCP] and any other Provider from which the Covered Person is currently receiving a course of treatment, as reported to Us. The 30-day prior notice may be waived in cases of immediate termination of a Practitioner based on a breach of contract by the Practitioner, a determination of fraud, or where Our medical director is of the opinion that the Practitioner is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the contract rate by a terminated Practitioner for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated Practitioner. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the Practitioner for the duration of the treatment or for up to six months, whichever occurs first.

For a Covered Person who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the Practitioner for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Covered Person receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the Practitioner regardless of whether the acute care Facility is under contract or agreement with Us.

Services shall be provided to the same extent as provided while the Practitioner was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the Practitioner while the Practitioner was employed by or under contract with Us.

If a Covered Person is admitted to a health care Facility on the date this [Policy] is terminated, We shall continue to provide benefits for the Covered Person until the date the Covered Person is discharged from the Facility or exhaustion of the Covered Person's benefits under this [Policy], whichever occurs first.

We shall not continue services in those instances in which the Practitioner has been terminated based upon the opinion of Our medical director that the Practitioner is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a Practitioner. The determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a Practitioner shall be subject to the appeal procedures set forth in this [Policy]. We shall not be liable for any inappropriate treatment provided to a Covered Person by a Practitioner who is no longer employed by or under contract with Us.

If We refer a Covered Person to a Non-Network Provider, the service or supply shall be covered as a network service or supply. We are fully responsible for payment to the Practitioner and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.]

*[**Note**: Include this text if the plan is issued as a managed care plan]*

[Service Area]
[Carrier must include a description of the Service Area, as required by N.J.A.C. 8:38-17.3(a)11]

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Provider may be paid] [each time he or she treats a Covered Person ("fee for service"] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a Covered Person desires additional information about how [Carrier's] primary care physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Covered Person wants more information about this, contact the Covered Person's physician, chiropractor or podiatrist. If a Covered Person believes he or she is not receiving the information to which he or she is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

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

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered [Charges] [Services or Supplies] that exceed the Deductible applicable to wellness benefits before We [pay any benefits] [cover services or supplies] for those charges. The Deductible is shown in the Coverage Schedule of this [Policy]. The Deductible cannot be met with Non-Covered [Charges] [Services or Supplies]. Only Covered [Charges] [Services or Supplies] You [incur] [receive] for wellness services and supplies while insured can be used to meet the Deductible for those charges.

Once the Deductible is met, We [pay benefits] [provide coverage] for other wellness benefits above the Deductible amount incurred by You, subject to the Coinsurance requirement and maximum benefit. But all charges must be incurred while You are insured by this [Policy].

Copayment: You must pay the applicable Copayment for each of the services shown in the Coverage Schedule. After the payment of the Copayment, We will pay [the Reasonable and Customary Charges] *[Note to carriers: Carriers may omit the reference to reasonable and customary if issued as an HMO plan.]* for services and supplies, subject to the applicable Coinsurance, coverage limits and maximum benefits as shown in the Coverage Schedule. [You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: Include this text if there is a possibility of balance billing.]*

Coinsurance: Coinsurance is the percentage of a Covered Charge that a Covered Person must pay for services and supplies as shown in the Coverage Schedule.

COVERED [CHARGES] [SERVICES OR SUPPLIES]

We will [pay benefits] [provide coverage] for Medically Necessary and Appropriate treatment of an Injury or Illness and for Wellness benefits subject to the terms and conditions of this [Policy].

[Any of the following services which are covered on an outpatient basis are covered only at the Primary Care Physician's office selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] or [Care Manager]. Services of a Specialist Practitioner which are covered under this [Policy] are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office 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]. The Inpatient 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 subject to Our preapproval.] *[Note to carriers: Include if issued as a managed care plan.]*

[OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS [POLICY].] *[Note to carriers: Include only if the Utilization Review text is included.]*

This section lists the types of [charges] [services or supplies] 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 and Substance Abuse: We [pay benefits] [provide coverage] for Inpatient and Outpatient treatment of Alcoholism and Substance Abuse. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement and the Alcohol and Substance Abuse Coinsurance as shown on the Coverage Schedule. [Benefits] for Outpatient care [are] [is] subject to the payment of the Alcohol and Substance Abuse Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Alcohol and Substance Abuse are separate from the Coverage Limits for Hospital Confinement.

Treatment may be furnished by a Hospital or Substance Abuse Center.

Anesthetics and the administration of anesthesia: We cover anesthetics and their administration.

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.

Biologically–based Mental Illness: We [pay benefits] [provide coverage] for the treatment of a Biologically-based Mental Illness, if such treatment is prescribed by a Practitioner. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Inpatient care for Biologically Based Mental Illness as shown on the Coverage Schedule. Benefits for Outpatient care are subject to the payment of Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Biologically Based Mental Illness are separate from the Coverage Limits for Hospital Confinement.

Blood and blood plasma: We cover blood, blood products and blood transfusions.

Complications of Pregnancy: We cover treatment for the complications of pregnancy.

Diagnostic Tests: We cover Inpatient and Out-of Hospital diagnostic testing. Benefits for Out-of Hospital Diagnostic Tests are limited, as shown in the Coverage Schedule.

Dialysis: We cover charges for Inpatient and Outpatient dialysis. This includes hemodialysis and peritoneal dialysis.

Emergency Room Services: Coverage for Emergency includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending Practitioner, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. Benefits for Emergency Room Services are subject to the payment of the Copayment as shown on the Coverage Schedule. We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical condition exists. [Please note that the "911" emergency response system may be used whenever a Covered person has a potentially life-threatening condition. Information on the use of the "911" system is included in the identification card.] *[Note to carriers: Include this text for managed care plans.]*

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. We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Practitioner's fees connected with Hospital care, general acute care, delivery of a child, Surgery, laboratory fees, prescription drugs, dressings and splints.

[Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement as shown on the Coverage Schedule. *Note*: The Coverage Limits for Hospital Confinement are separate from the Coverage Limits for Alcohol and Substance Abuse and Biologically Based Mental Illness.

If You [incur charges] [receive services or supplies] as an Inpatient in a Special Care Unit, We cover the [charges] [services or supplies] the same way We cover other Hospital [charges] [services or supplies].

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered [Charges] [Services or Supplies].

We cover charges for treatment rooms, operating rooms and delivery rooms.

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;
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; and
c) adult immunizations.

Intravenous Solutions: We cover intravenous solutions administered while an Inpatient or in an Outpatient setting.

Oxygen: We cover charges for oxygen and the administration of oxygen.

Practitioner Charges for Outpatient and Ambulatory Surgery: We cover Practitioner charges for Outpatient and ambulatory Surgery. [Benefits] [Coverage] for Outpatient and ambulatory Surgery [are] [is] subject to the payment of the Copayment as shown on the Coverage Schedule. 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 also cover dressings and splints.

Practitioner Charges for Visits: We cover Practitioner charges for visits to treat a diagnosed Illness or Injury. Benefits are limited, as shown on the Coverage Schedule. We also cover dressings and splints.

Pregnancy: As stated in the Hospital Charges section, We cover Practitioner's fees for the delivery of a Child and charges for the use of the delivery room.

Pre-Admission Testing: We cover x-rays and laboratory tests in connection with 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.

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

We only cover the Therapy Services listed below.
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.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following Illness, Injury or loss of limb; or treatment related to a Biologically-based Mental Illness to develop a physical function.
Hydrotherapy – the medical use of water in the treatment of certain diseases.

We cover Radiation Therapy and Physical Therapy when it is provided on an Inpatient basis and on an Outpatient basis. We only cover Hydrotherapy when it is provided on an Inpatient basis. Benefits for Outpatient Physical Therapy are subject to the payment of the Copayment shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

Wellness Benefit: We cover wellness services and supplies. Wellness services and supplies include but are not limited to: routine physical examinations, diagnostic services, vaccinations, inoculations, x-ray, mammography, pap smear, bone density testing, nicotine dependence treatment, screening tests related to wellness services. Benefits are subject to the payment of the Deductible and Coinsurance as shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

X-Rays: We cover x-rays to diagnose an Illness or Injury. X-Rays done on an Outpatient basis are subject to the limit for Outpatient diagnostic tests as shown on the Coverage Schedule. Except as covered under the Wellness benefit section of this [Policy], We do not pay for x-rays done as part of routine physical checkups.

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. If coverage is not issued as a result of the application, the period from the Enrollment Date to the date the application is declined is excluded from the period without 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 Covered Person's Enrollment Date under this [Policy], measured from the last date the Creditable Coverage was in force on a premium paying basis.

[Note to carriers: The following Utilization Review text should not be included if issued by an HMO]

[UTILIZATION REVIEW FEATURES

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

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

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

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

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

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

Grievance Procedure
[Carriers must include the disclosure requirements set forth in N.J.A.C. 8:38A-3.2]

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

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

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

b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.
When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

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

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

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

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

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

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. We reduce what We pay for covered Hospital charges, by 50% if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet this [Policy's] Cash Deductible or Coinsurance.

[REQUIRED PRE-SURGICAL REVIEW

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

We require a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

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

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

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

Penalties for Non-Compliance
As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this [Policy's] Cash Deductible or Coinsurance.

EXCLUSIONS

The following are <u>not</u> Covered [Charges] [Services or Supplies] under this [Policy]. We will <u>not</u> 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

[Any charge to the extent it exceeds the Reasonable and Customary Charge] *[Note to carriers: Carriers may omit this exclusion if issued as an HMO plan.]*

[Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.] *[Note to carriers: Include if issued as a plan that requires referrals.]*

Any service or supply not specifically included in the Covered [Charges] [Services and supplies] section of this [Policy].

Birthing center charges

Blood or blood plasma which is replaced by You

Broken appointments

Casts, braces, trusses, prosthetic devices, orthopedic footwear and crutches

Chemotherapy

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 and dental implants

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

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]

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 or lasik surgery

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility

Food and food products

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them

Herbal medicine

Home health care

Hospice care

Hypnotism

Except as stated below, 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.

Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Infusion therapy

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

Nicotine Dependence Treatment, except as provided for under the wellness benefit

Non - Prescription Drugs or supplies

Nutritional counseling and related services

Outpatient Hospital services, except as specifically covered under this [Policy]

Outpatient laboratory tests, except as provided under the Wellness Benefit or the Pre-Admission Testing benefit.

Pregnancy, including charges for pre and post natal care, except Practitioner charges for delivery and charges for the delivery room are covered. Complications of pregnancy are also covered.

Prescription drugs obtained while not confined in a Hospital

Private duty nursing

Rehabilitation center charges

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 wellness 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

Second opinion charges

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 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 an 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;
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.

Skilled Nursing Facility charges

Skilled nursing care charges

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

Temporomandibular Joint Disorder (TMJ) Treatment

Therapeutic Manipulation

Therapy services, except as specifically covered under this [Policy]

Transplants, except to the extent a service or supply associated with a transplant is specifically covered under this [Policy].

Transportation; travel

Treatment of a Non-Biologically-based Mental Illness

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

[Note to carriers: Include the Claims Procedures text in plans that require claims submissions.]

[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 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 and 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 [Policy]holder;
b) [Policy]holder'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.

[Include the Claims Procedures provision in plans that require the submission of claims.]

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. or N.J.A.C. 8:38A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

GRIEVANCE PROCEDURE
[Carriers must include the disclosure requirements set forth in N.J.A.C. 8:38A-3.2].

[Note to carriers: Include the following member provisions if coverage is issued as an HMO plan.]

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 [Policy] 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 [Policy] is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this [Policy], and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the [Policy]holder, coverage may be terminated for the [Policy]holder as well as any of the [Policy]holder's Dependents who are Members. To be eligible for services or benefits under this [Policy], the holder of the card must be a Member on whose behalf all applicable premium charges under this [Policy] have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this [Policy] 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 [Policy] 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 [Policy], or similar causes, the rendition of medical or hospital benefits or other services provided under this [Policy] 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. In the event We cannot provide or arrange for any services for three or more days We will refund premium for that period for which no services are available.

LIMITATION ON SERVICES
Except in cases of Emergency, services are available only from [Network] [Participating] Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT
[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service")] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

MEDICAL NECESSITY
Members will receive designated benefits under the [Policy] only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the [Policy] 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 [Policy] 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 [Policy].

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 [Policy] 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 the 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 [Policy] 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 his or her coverage under this [Policy]. In such event, We will continue to provide all benefits covered by this [Policy] 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 in accordance with this [Policy]. 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 [Policy] subject to all applicable confidentiality requirements as defined in this [Policy]. By accepting coverage under this [Policy], [Policy]holder, for the [Policy]holder, 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
When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician.

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 an 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 [Biologically Based, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

COORDINATION OF BENEFITS AND SERVICES WITH MEDICARE

Purpose Of This Provision
A Member may be covered under this Policy 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. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

Please note: The ONLY circumstance in which a person may be covered under this Policy and under Medicare occurs when a Covered Person is already covered under this Policy and subsequently becomes eligible for Medicare.

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

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under this Policy, or Medicare, except where a statute requires another definition, or as otherwise stated below.

We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by this Policy and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

PRIMARY AND SECONDARY PLAN
We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual policy, Medicare is always the Primary Plan and this Policy is always the Secondary Plan. Medicare pays or provides services or supplies first, without taking into consideration the existence of this Policy.

This Policy takes into consideration the benefits provided by Medicare. During each Claim Determination Period, this Policy will pay up to the remaining unpaid allowable expenses, but this Policy will not pay more than it would have paid if it had been the Primary Plan. The method this Policy uses to determine the amount to pay is set forth below in the **"Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

This Policy shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable deductible, coinsurance or copayment. If the Covered Person uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The Covered Person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Covered Person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan
If the Covered Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan
If the Covered Person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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 New Jersey 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 New Jersey 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

AMENDMENT
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 Our officers have 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 one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the 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 one of Our officers.
c) if a change is required by Us, 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 one of Our officers.

ASSIGNMENT
No assignment or transfer by the Policyholder of any of the Policyholder's interest under this Policy or by a Covered Person of any of his or her interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error nor programming or systems error by the Policyholder or by Us in keeping any records pertaining to coverage under this Policy will reduce a Covered Person's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Except as described in the **Premium Amounts** section, premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

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

CONFORMITY WITH LAW
Any provision of this Policy which, is in conflict with the laws of the State of New Jersey, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

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 the Policyholder or by a Covered Person covered under this Policy shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

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

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 with the Policyholder.

If to the Policyholder: To the last address provided by the Policyholder on an enrollment or change of address form actually delivered to Us.

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

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by You to Us. They are due on each premium due date. 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 without premium payment during the grace period and this Policy 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.]

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid premiums or claims payment previously made to You in error.

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. [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.] 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 Member 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 [Premium Rates and Provisions section of the Policy] [Policy's Schedule of Premium Rates]. We have the right to prospectively 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.

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

All statements will be deemed representations and not warranties.

TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

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

We have the right to non-renew this Policy on the Policy Anniversary date following 180 days advance written notice to the Policyholder for the following reasons:
a) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
c) the Board terminates a standard plan or a standard plan option.

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.] [as of the end of the period for which premium has been paid.]
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.] [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 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 individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)

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.

THE CONTRACT
The entire Contract 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.

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

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP ENDS

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

Exceptions

No former Spouse may use this conversion right:

a) if he or she is eligible for Medicare;

b) if it would cause him or her to be excessively covered; This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after coverage under this Policy ends.

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit V and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit F, recodified as N.J.A.C. Appendix Exhibit B.
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).

EXHIBIT G

[Carrier]

Plan Update Rider

This rider amends standard [indemnity] [PPO] individual health benefits plan [A/50] [B] [C] [D].
Effective Date:

1. The **Deductible Credit** provision of the **BENEFIT PROVISION** section is deleted and replaced with the following:

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.

2. A new provision entitled **Coinsurance Credit** is added to the **BENEFIT PROVISION** section immediately following the Deductible Credit provision.

[Coinsurance Credit: A Covered Person will receive credit for any Coinsurance amounts, **including amounts paid for prescription drugs**, the Covered Person satisfied from January 1 of the Calendar Year in which this Policy is issued, subject to the following requirements:
a) The policy this Policy replaces had the same coinsurance and deductible as this Policy; and
b) The policy this Policy replaces was also issued by Us.

As of the Effective Date of this Policy, and for the balance of the first Calendar Year, the Coinsurance amounts the Covered Person paid during the same Calendar Year that were accumulating toward the satisfaction of the Coinsurance Cap will be applied toward the satisfaction of the Maximum Out of Pocket under this Policy.

Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs **on or after the effective date of this Policy** does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use the above Coinsurance Credit text for indemnity plans.]

[Coinsurance Credit: If a Covered Person satisfied the Coinsured Charge Limit between January 1 of the Calendar Year in which this Policy is issued and the Effective date of this Policy, the Covered Person will receive credit for such satisfaction, subject to the following requirements:
a) The policy this Policy replaces had the same Copayment, Coinsurance and Deductible as this Policy; and
b) The policy this Policy replaces was also issued by Us.

As of the Effective Date of this Policy, and for the balance of the first Calendar Year, the Covered Person will be considered to have satisfied the Maximum Out of Pocket under this Policy.

Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs **on or after the Effective Date of this Policy** does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

[Note to Carriers: Use the above Coinsurance Credit text for PPO plans.]

This Rider terminates as of December 31 of the Calendar Year in which it was issued.

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).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Amended by R.2002 d.331, effective October 7, 2002.
See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Expired, effective July 4, 2005.
See: 37 N.J.R. 2994(a).
New Rule, R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).

EXHIBIT H

(RESERVED)

Expired, effective July 4, 2005.
See: 37 N.J.R. 2994(a).

EXHIBIT I

(RESERVED)

Repeal and New Rule, R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Section was "Exhibit I".
Expired, effective July 4, 2005.
See: 37 N.J.R. 2994(a).

EXHIBIT J

Loss Ratio Report Form
New Jersey Individual Health Coverage Program

Reporting Year _____, 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 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 x (ii ÷ iii)]= $ _____
   - i. Total net paid loss assessment $ _____
   - ii. Net earned premium for standard health benefits plans $ _____
   - iii. Net earned premium 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. 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

Facsimile Number

Amended by R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

EXHIBIT K

New Jersey Individual Health Coverage Program Assessment Report
For the Two-Year Calculation Period _____-_____

All carriers reporting accident and health premium to the New Jersey Department of Banking and Insurance shall submit this report and attachments in accordance with the provisions of N.J.A.C. 11:20-8. Reports must be completed and returned on or before April 1, 2007 and by April 1 of the first year of each two-year calculation period thereafter, to the Executive Director, IHC Program, PO Box *325,* (20 West State Street), Trenton, NJ 08625-0325.

Part A. Carrier Information

1. Carrier's name: _____ 2. NAIC Number: _____
3. Full name of all affiliated carriers reporting any accident and health premium in New Jersey

_____
_____
_____

Part B. Information of Person Completing this Report

1. Name (print or type): _____ 2. Title: _____
3. Telephone No.: _____ Facsimile No.: _____ E-mail: _____
4. Mailing Address: _____
_____

Part C. Program Membership for the Two-Year Calculation Period (Attach worksheet(s))

Members and Non-members with reportable accident and health premium in New Jersey MUST complete and return one copy of the attached "Exhibit K-Part C Premium Data Worksheet" for each of the affiliates listed above. If any of the affiliates has any net earned premium for the two-year period, the carrier is a Member and shall record the amount below. If no affiliates have net earned premium, then the carrier is a Non-member and the carrier shall check the Non-member box below.

Member's net earned premium, including all affiliates, for the two-year period:
$ _____; or
☐ Non-member of the IHC Program with no net earned premium

Part D. Number of Non-group Persons Enrolled by Member Carrier (Attach worksheet(s))

Members MUST complete and return one copy of the attached "Exhibit K Part D Enrollment Data Worksheet" for each of the affiliates listed above that issued or renewed non-group enrollment as listed on the attached Worksheet.

Average non-group enrollment for the two-year period: _____

Part E. Member's Net Paid Gain (Loss) for Individual Health Benefits Plans

a. PREMIUM EARNED	$_____
b. CLAIMS PAID	$_____
c. NET INVESTMENT INCOME	$_____
d. NET PAID GAIN (LOSS) [115% (a+c)]-b	$_____

Part F. Certification

I certify that I am an officer of the company, that the information provided in this report and all attachments is accurate and complete, and that it has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

_____ _____ _____
Name of Officer Title Date

Exhibit K Part C Premium Data Worksheet

The purpose of this Part C Premium Data Worksheet is to demonstrate whether a carrier is a member of the IHC Program by virtue of having any "net earned premium" during the two-year calculation period. "Net earned premium" means the premiums earned in this State on "health benefits plans," less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Health benefits plans include, but may not be limited to the following coverages: health insurance for individuals or groups of any size; Medicare + Choice contracts (premium should be limited to premium from insureds); Medicare Cost and Risk; premium from Medicare Demonstration plans, Medicaid; New Jersey FamilyCare Part A and NJ KidCare Part A; accident medical; student accident and health medical if expense incurred; specified disease if expense incurred; and limited benefits if expense incurred; and Champus or TriCare. The attached report provides a carrier with a framework for accurately calculating its net earned premium. The definitions of "net earned premium" and "health benefits plans" are set forth at N.J.A.C. 11:20-1.2.

Directions:

Copy the attached worksheet, if necessary, and provide the following information for each affiliate:

- The name of the affiliate.
- Section 1: The total accident and health premium reported on the annual NAIC statement blank for both calendar years of the two-year calculation period for that affiliate.

- Section 2: The total premium amounts earned in each calendar year of the two-year calculation period for each of the excepted types of coverage listed on the worksheet for each affiliate.
- Section 3: To arrive at the net earned premium in section 3, subtract the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1. All premium that is not from some type of excepted coverage is net earned premium from health benefits plans.
- Each affiliate's worksheet shall be attached to the carrier's one-page Exhibit K.

Members shall report the combined two-year net earned premium calculated from each affiliate's Exhibit K Part C Premium Data Worksheet on Part C of the Exhibit K Assessment Report.

If the combined two-year net earned premium total from each affiliate's Exhibit K Part C Premium Data Worksheet is zero either because all of the premium is from excepted coverages or because the carrier had no accident and health premium, then the carrier shall assert Non-member status by checking the Non-member box on Exhibit K Part C, and completing the certification in Part F.

Exhibit K Part C Premium Data Worksheet for the Two-Year Calculation Period _____-_____

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page for each affiliate along with Exhibit K.

Section 1: Total A&H Premium	Premium for 1st Year of 2-Year Period	Premium for 2nd Year of 2-Year Period	Two-Year Total
Amount of Accident & Health Premium on New Jersey NAIC Statement Blank:			

Section 2: List of Excepted Benefits and Premium	Premium for 1st Year of 2-Year Period	Premium for 2nd Year of 2-Year Period	Total for 2-year Period
a. Medicare + Choice coverage (excepted premium amount is limited to amounts paid by federal government and does not include premium paid insureds)	$	$	$
b. contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. §§8901-8914	$	$	$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	$	$	$
d. Medicare supplement policies or contracts	$	$	$
e. non-expense incurred specified disease coverage	$	$	$
f. coverage only for accident, disability income insurance, or any combination	$	$	$
g. coverage issued as a supplement to liability insurance	$	$	$
h. liability insurance, including general liability insurance and automobile liability insurance	$	$	$
i. workers' compensation or similar insurance	$	$	$
j. automobile medical payment insurance	$	$	$
k. credit-only insurance	$	$	$
1. coverage for on- site medical clinics	$	$	$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits	$	$	$
n. limited scope dental or vision benefits*	$	$	$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	$	$	$
p. such other similar, limited benefits as are specified in federal regulations*	$	$	$
q. 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	$	$	$
r. coverage supplemental to the coverage provided under chapter *55* of Title 10, United States Code (10 U.S.C. § 1071 et seq.)	$	$	$
s. similar supplemental coverage provided to coverage under a group health plan	$	$	$

Total excepted premium:	$	$	$

* Include as an excepted benefit if the coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan.

Section 3: Calculation of "Net Earned Premium"	Premium for 1st Year of 2-Year Period	Premium for 2nd Year of 2-Year Period	2-year Net Earned Premium Total
Net Earned Premium = (Section 1 premium – Section 2 premium))	$	$	$

Exhibit K Part D Enrollment Data Worksheet
for the Two-Year Calculation Period _____-_____

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page with Exhibit K.

For a through e below, provide the number of covered lives as of the end of each calendar quarter during the Two-Year Calculation Period for each of the categories of coverage described below, and the two-year total for each category. Non-members should be reporting no covered lives in any of the categories below because premium from all of the coverage listed below result in net earned premium.

Total Q1-Q8

a. Persons covered under standard individual health benefits plans or basic and essential health care services plans

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

b. Community rated conversion policy persons

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

c. Medicaid recipients (Include NJ FamilyCare Part A, NJ KidCare Part A but no other NJ FamilyCare or NJ KidCare lives)

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

d. Medicare Plus Choice lives, Medicare Risk and Cost lives, Medicare Demonstration Project lives (Do not include Medicare Supplement)

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

e. Two-Year non-group enrollment total (Total Q1-Q8 for a through d): _____

f. Average two-year non-group enrollment to be reported on Exhibit K Part D (line e divided by 8): _____

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Exhibit K: New Jersey Individual Health Coverage Program; Carrier Market Share and Net Paid Gain (Loss) Report".

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

New Jersey Individual Health Coverage Program
Quarterly Enrollment Report - Part 1 of Exhibit L

Carrier:	
Respondent:	
Phone:	Fax:
Email:	

Quarter Reported:

	Issued Prior	Standard Plans													Basic & Essential Plans		Totals
		Plan A/50		Plan B		Plan C		Plan D		HMO Plans					Indemnity,	HMO	
A. Report by Contracts	to 8/1/93	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Copay	50% Coins	40% Coins	30% Coins	20% Coins	PPO/EPO	Plans	
I. Contracts Inforce Beginning of Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Contracts Issued During Period		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
1. Contracts Issued to Previously Insured Individuals		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
2. Contracts Issued to Previously Uninsured Individuals		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Contracts Issued with Unknown Prior Insured Status		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Contracts Lapsed During Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Contracts Inforce End of Period (I+II-III)*	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
B. Report by Persons Insured																	
I. Insureds Beginning of Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. New Insureds During Period		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Insureds Lapsed During Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Insureds End of Period (I+II-III)	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
C. Report of Contracts by Rating Tier																	
I. Single Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Two Adult Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Adult and Child(ren) Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Family Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
V. Contracts Inforce End of Period (I+II+III+IV)*	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
D. Report of Contracts by Deductible/Copayment Option																	
I. Contracts with $1,000 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
II. Contracts with $2,500 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
III. Contracts with $5,000 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
IV. Contracts with $10,000 Deductible		-	-	-	-	-	-	-	-								-
V. Contracts with $15 Copay			-		-		-		-	-						-	-
VI. Contracts with $30 Copay			-		-		-		-	-						-	-
VII. Contracts with $40 Copay			-		-		-		-	-						-	-
VIII. Contracts with $50 Copay			-		-		-		-	-						-	-
IX. Contracts with HDHP Deductibles (MSA provisions) - *renewal business only*							-		-								-
X. Contracts with HDHP Deductibles (HSA Provisions)		-	-	-	-	-	-	-	-								-
XI. Contracts Issued as Basic & Essential Plans - without any rider															-	-	-
XII. Contracts Issued as Basic & Essential Plans - with a rider															-	-	-
XIII. Contracts with $500 Deductible, $10 or $20 Copay - *runoff business only*									-	-							-
XIV. Contracts Inforce End of Period (I+II+III+IV+V+VI+VII+VIII+IX)*		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
% of Contracts Issued to Persons Previously Uninsured	-																

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[*NOTE: A.IV = C.V = D.XIV]

New Jersey Individual Health Coverage Program
Annual Enrollment Report - Part 2 of Exhibit L

Carrier:	
Respondent:	
Phone:	**Fax:**
Email:	

Year Reported:

	Standard Plans									Basic & Essential Plans				
	Plan A/50		Plan B		Plan C		Plan D		HMO	Indemnity,	Indemnity,	HMO	HMO	Total
	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Plans	PPO/EPO with rider	PPO/EPO w/o rider	with rider	w/o rider	Plans
A. Report of Inforce Contracts by Zip Code														
Territory A (070-073)	-		-	-	-	-	-	-	-	-			-	-
Territory B (074-076)	-		-	-	-	-	-	-	-	-			-	-
Territory C (077-079)	-		-	-	-	-	-	-	-	-			-	-
Territory D (088-089)	-		-	-	-	-	-	-	-	-			-	-
Territory E (081, 085-086)	-		-	-	-	-	-	-	-	-			-	-
Territory F (080, 082-084, 087)	-		-	-	-	-	-	-	-	-			-	-
Total	-		-	-	-	-	-	-	-	-			-	-
B. Report of Insured Males														
Age 0-24	-		-	-	-	-	-	-	-	-			-	-
Age 25-29	-		-	-	-	-	-	-	-	-			-	-
Age 30-34	-		-	-	-	-	-	-	-	-			-	-
Age 35-39	-		-	-	-	-	-	-	-	-			-	-
Age 40-44	-		-	-	-	-	-	-	-	-			-	-
Age 45-49	-		-	-	-	-	-	-	-	-			-	-
Age 50-54	-		-	-	-	-	-	-	-	-			-	-
Age 55-59	-		-	-	-	-	-	-	-	-			-	-
Age 60-64	-		-	-	-	-	-	-	-	-			-	-
Age 65-69	-		-	-	-	-	-	-	-	-			-	-
Age 70 & Over	-		-	-	-	-	-	-	-	-			-	-
Total	-		-	-	-	-	-	-	-	-			-	-
C. Report of Insured Females														
Age 0-24	-		-	-	-	-	-	-	-	-			-	-
Age 25-29	-		-	-	-	-	-	-	-	-			-	-
Age 30-34	-		-	-	-	-	-	-	-	-			-	-
Age 35-39	-		-	-	-	-	-	-	-	-			-	-
Age 40-44	-		-	-	-	-	-	-	-	-			-	-
Age 45-49	-		-	-	-	-	-	-	-	-			-	-
Age 50-54	-		-	-	-	-	-	-	-	-			-	-
Age 55-59	-		-	-	-	-	-	-	-	-			-	-
Age 60-64	-		-	-	-	-	-	-	-	-			-	-
Age 65-69	-		-	-	-	-	-	-	-	-			-	-
Age 70 & Over	-		-	-	-	-	-	-	-	-			-	-
Total	-		-	-	-	-	-	-	-	-			-	-

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New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(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".