a) the Medical Necessity and Appropriateness;
b) the type of service involved;
c) the appropriate level of care required; and
d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co- Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:
a) days of Inpatient care per Calendar year; and
b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:
a) the Covered Person does not request a review in the times and manner described above;
b) the Covered Person's treatment does not comply with the treatment plan;
c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
d) [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.
[Carrier should insert Standard Rider Closure.]

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT J

CARD/MAIL (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides.
m) Drugs for the management of nicotine dependence.
n) Drugs used in connection with baldness.
o) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
p) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
q) Drugs dispensed to a [Member] while on active duty in any armed force.
r) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
s) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

CARD (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

MAIL (HMO)

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is supplemented with the following:

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Mail Order Pharmacy;
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:

a) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.

j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider Closure]

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT K

PART 1
EXPLANATION OF BRACKETS-POLICY *AND CERTIFICATE* FORMS

(Plans A,B,C,D,E)

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 explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO or POS)
h) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 16 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 17 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets (HMO Plan), set forth in Part 2 of Exhibit K, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

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 and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and Co-Insurance Cap must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note**: ALL plans issued by a Carrier MUST include the same option.
4. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
5. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy - Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
8. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
9. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
10. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
11. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
12. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
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. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the Penalty for Non-Compliance with Pre-Certification Requirements section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a) the Medical Necessity and Appropriateness;
b) the type of service involved;
c) the appropriate level of care required; and
d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a) days of Inpatient care per Calendar year; and
b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:
a) the Covered Person does not request a review in the times and manner described above;
b) the Covered Person's treatment does not comply with the treatment plan;
c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
d) [XYZ] does not confirm the need for such care or treatment.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).

EXHIBIT AA

CARD/MAIL (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program:
b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.
[Carrier should insert Standard Rider Closure]

CARD (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

Insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Participating Provider.

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin, insulin needles and insulin syringes; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment
A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs $5.00
•for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Pharmacy; and
c) needed to treat an Illness or Injury.

A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.

h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.
q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure]

MAIL (HMO)

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:
Group Contract No.:
Effective Date:

The Prescription Drug item of the Outpatient Services section of the **Covered Services and Supplies** Section of the HMO Evidence of Coverage is supplemented with the following:

This **Rider for Prescription Drug Coverage** will provide benefits for covered drugs including contraceptive drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:
a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:
a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a [Member] can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription.

Copayment

A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Copayment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:
•for Generic Drugs NONE
•for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:
a) prescribed by a Participating Provider (except for insulin)
b) dispensed by a Participating Mail Order Pharmacy;
c) needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than:
a) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and
b) the amount usually prescribed by the [Member's] Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a) Administration of a Prescription drug.
b) Immunization agents
c) Biological sera
d) Blood or Blood Plasma
e) Prescription Drugs labeled "Caution - limited by Federal Law to Investigational use" or experimental
f) Refills in excess of the amount specified by the prescribing Participating Provider
g) Refills dispensed after one year from the original date of the prescription.
h) Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i) Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
•a Hospital
•a rest home
•a sanitarium
•a Skilled Nursing Center
•a Substance Abuse Center
•an alcohol abuse or mental health center
•a convalescent home
•a nursing home
or similar institution.
j) Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.
k) Vitamins, except for Legend Drug vitamins.
l) Topical dental Fluorides. l. Drugs for the management of nicotine dependence.
m) Drugs used in connection with baldness.
n) Drugs needed due to conditions caused, directly or indirectly, by a [Member] taking part in a riot or other civil disorder; or the [Member] taking part in the commission of a felony.
o) Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p) Drugs dispensed to a [Member] while on active duty in any armed force.

q) Drugs furnished by the [Member's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r) Drugs needed due to an on-the job or job related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure]

New Rule,R.1995 d.47, effective December 22,1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT BB

PART 1

CERTIFICATION OF COMPLIANCE WITH SMALL EMPLOYER HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:21-4.2, submit this form, by March 1 of every year, to the SEH Board at the address specified at N.J.A.C. 11:21-1.3. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name:_____ NAIC #:_____
If an HMO, is the Carrier federally qualified?
_____Yes _____No

Respondent's Name:_____

Respondent's Title:_____

Respondent's Address:_____

_____

Respondent's Telephone:_____FAX:_____

2. COMPLIANCE

Check the appropriate response(s).

_____(a) Plans A, B, C, D and E comply fully with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(b) Plans A, B, C, D and E comply with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A through F and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21, BUT an alternative method of utilization review, as permitted at N.J.A.C. 11:21-4, is being submitted for review and approval or has already been approved by the SEH Board.

_____(c) HMO Plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibit G and K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(d) The HMO/POS plan complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibits HH and JJ of the Appendix to N.J.A.C. 11:21, and the HMO is in compliance with Department of Health and Senior Services regulations governing an HMO's ability to offer out-of-network services set forth at N.J.A.C. 8:38-14.

_____(e) All standard riders applicable to Plans A through E comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth in Exhibits H, and I and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(f) All standard riders applicable to the HMO Plan comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth at Exhibit J and K, respectively, of the Appendix to N.J.A.C. 11:21. **NOTE**: Since none of the standard riders applicable to the HMO Plan may be used with the HMO/POS Plan, carriers that wish to offer riders with the HMO/POS Plan must file optional benefit riders which are specifically designed to amend the HMO/POS Plan.

_____(g) All applications, certifications, enrollment forms, waiver forms, certificates or evidence of coverage comply with the SEH Board's forms set forth in Exhibits N, O, Q, T, V. W, Y, Z, AA, and II the explanation of Brackets set forth at Exhibit K and JJ in the Appendix to N.J.A.C. 11:21.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section (please use "NA" to indicate when a section is not relevant). Attach additional pages as necessary.

(a) **Plans A through E (To be completed by non-HMO carriers)**

(1) Identify the standard plans offered as a **traditional contract**:

Plan A:_____ Plan B:_____ Plan C:_____ Plan D:_____ Plan E:_____