CHAPTER 21

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, and 17B:27A-17 et seq.; and P.L. 2007, c. 345 and P.L. 2008, c. 38.

Source and Effective Date

R.2009 d.277 and d.278, effective August 18, 2009. See: 41 N.J.R. 84(a), 41 N.J.R. 1147(a), 41 N.J.R. 3444(a), 41 N.J.R. 3451(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 10, 17, 18, and 23, and Appendix Exhibits D, F, G, K, T, W, Y, BB, CC, DD, HH, and II, expire on February 14, 2017. See: 48 N.J.R. 1564(a).

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 21, Small Employer Health Benefits Program, Subchapters 7A, 9, 15, and 16, and Appendix Exhibit GG, expire on February 14, 2017. See: 48 N.J.R. 1902(a).

Chapter Historical Note

Chapter 21, Small Employer Health Benefits Program, was adopted as R.1993 d.553, effective October 15, 1993. See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as R.1993 d.551, effective October 15, 1993. See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a).

Subchapter 15, Relief From Obligations Imposed Under the Small Employer Health Benefits Program, was adopted as R.1993 d.629, effective November 5, 1993. See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

Subchapter 6, Standard Employer and Employee Application and Small Employer Certification Forms, Subchapter 7, Program Compliance, Subchapter 17, Fair Meeting Standards, and Subchapter 18, Petitions for Rules, were adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 30 N.J.R. 5668(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was adopted as R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

Subchapter 9, Informational Rate Filing Requirements Pursuant to the Small Employer Health Benefits Program, was adopted as R.1994 d.25, effective December 9, 1993. See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

Subchapter 16, Withdrawals of Small Employer Carriers From the Small Employer Health Benefits Plans Market, was adopted as R.1994 d.26, effective December 9, 1993. See: 25 N.J.R. 4859(a), 26 N.J.R. 247(a).

Subchapter 2, New Jersey Small Employer Health Benefits Program Plan of Operation, was adopted as R.1994 d.48, effective December 22, 1993. See: 25 N.J.R. 4563, 26 N.J.R. 391(a).

Subchapter 8, Carrier Certification of Non-Member Status, and Subchapter 10, The Market Share Report, were adopted as R.1994 d.228, effective April 11, 1994. See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was adopted as R.1994 d.580, effective November 21, 1994. See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was renamed Nonstandard Health Benefits Plans (Filings With the Commissioner): Requirements for Maintaining Nonstandard Plans, and Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Subchapter 19, SEH Program Premium Comparison Survey, was adopted as R.1995 d.289, effective June 5, 1995. See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

Subchapter 7A, Loss Ratio Reports; Dividends and Credits, was adopted as R.1996 d.213, effective May 6, 1996. See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was repealed and Subchapter 3A, Non-Standard Health Benefits Plans, was adopted as new rules by R.1997 d.62, effective February 3, 1997. See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Subchapter 13, Nonstandard Plans: Withdrawal of Plans, was adopted as R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Pursuant to Executive Order No. 66(1978), Subchapters 1 through 7, 8, 10, 17, 18, and Appendix Exhibits A through KK of Chapter 21, Small Employer Health Benefits Program, were readopted as the Small Employer Health Benefits Program Board as R.1998 d.512, effective September 25, 1998 and Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix were readopted as the Department of Banking and Insurance as R.1998 d.533, effective October 15, 1998. See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a); 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was adopted as R.1999 d.156, effective May 17, 1999. See: 31 N.J.R. 109(a), 31 N.J.R. 1357(a).

Subchapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 17, 18, 23 and Appendix Exhibits H, N, O, T, CC, DD, and KK were readopted as R.2004 d.107, effective February 19, 2004. Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix Exhibits BB, FF, and GG, were readopted as R.2004 d.108, effective February 19, 2004. As part of R.2004, d.107, Subchapter 5, Standard Claim Form, was repealed effective March 15, 2004. See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a); 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was readopted as R.2004 d.149, effective March 18, 2004. See: 36 N.J.R. 145(a), 36 N.J.R. 1942(a).

Subchapter 3A, Non-Standard Health Benefits Plans, expired on February 19, 2009.

Chapter 21, Small Employer Health Benefits Program, Subchapters 7A, 9, 11, 13, 15, 16, 19, 20 and 21, and Appendix Exhibits BB Parts 3 through 5, FF, and GG, were readopted as R.2009 d.277, effective August 18, 2009. See: Source and Effective Date. See, also, section annotations.

Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 8, 10, 17, 18, 23, and Appendix Exhibits A, D, F, G, H, K, N, O, T, V, W, Y, BB Parts 1, 2 and 6, CC, DD, HH, II and KK, were readopted as R.2009 d.278, effective August 18, 2009. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 10, 17, 18, and 23, and Appendix Exhibits D, F, G, K, T, W, Y, BB, CC, DD, HH, and II, were scheduled to expire on August 18, 2016. See: 43 N.J.R. 1203(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 21, Small Employer Health Benefits Program, Subchapter 11, Nonstandard Health Benefits Plans (Filings with the Commissioner): Requirements for Maintaining Nonstandard Plans, Subchapter 13, Nonstandard Plans: Withdrawal of Plans, Subchapter 19, SEH Program Premium Comparison Survey, Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, and Subchapter 21, Small Employer Purchasing Alliances, and Appendix Exhibit BB Parts 3 through 5 and Appendix Exhibit FF, expired on August 18, 2016. See: 43 N.J.R. 1203(a).

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SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended (N.J.S.A. 17B:27A-17 et seq.), herein referred to as the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A-17 et seq.

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

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

Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 2488(b), 26 N.J.R. 3089(a), 26 N.J.R. 3758(a).
Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 5120(a), 27 N.J.R. 1321(b).
Petition for Rulemaking: Exhibits A through G.
See: 26 N.J.R. 5120(c), 27 N.J.R. 946(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted additional P.L. references.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted references to P.L. 1993, 1994, and 1995 in the first sentence.

11:21-1.2 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 P.L. 1992, c.162, as adopted and subsequently amended (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carrier" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another carrier.

"Affiliated company" means a person that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another person. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

"Allowed charge" means an amount that is not more than the lesser of the allowance for the service or supply as determined by the standard approved by the Board as set forth at N.J.A.C. 11:21-7.13 or the negotiated fee schedule.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits 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 an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an

insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Carrier coinsurance" means the percentage of a covered charge paid by a carrier.

"Cash deductible" or "deductible" means the amount of covered charges that a covered person must pay before the health benefits plan pays any benefits for such charges.

"Coinsurance" means the percentage of a covered charge that must be paid by a covered person. Coinsurance does not include cash deductibles, copayment, or non-covered charges.

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

"Copayment" or "copay" means a specified dollar amount a covered person must pay for specified covered charges.

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

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan. The reference to "spouse" includes a civil union partner pursuant to P.L. 2006, c. 103, and same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage, except that spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c.246.

"Eligible employee" means a full-time, bona fide employee who works a normal work week of 25 or more hours. The term excludes a sole proprietor, a partner of a partnership, or an independent contractor and does not include employees who work less than 25 hours a week, work on a temporary or substitute basis, or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

"Employee" as used in paragraph 2 of the definition in this section of "small employer" means an individual who is an employee under the common law standard as described in 26 CFR 31.3401(c)-1. Employee excludes a sole proprietor, a partner in a partnership, and more than a two percent shareholder in a Subchapter S corporation as well as immediate family members of such individuals. Employee also excludes a leased employee.

"Employee open enrollment period" means the 30-day period each year designated by the small employer during which:

1. Employees and dependents who are eligible under the small employer's plan but who are late enrollees may enroll for coverage under the small employer's plan; and

2. Employees and dependents who are covered under the small employer's plan may elect coverage under a different policy, if any, offered by the small employer.

"Employer open enrollment period" means the period from November 15 through December 15 each year beginning in 2014.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment. If an employee changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

"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" (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 any hospital and medical expense insurance policy or certificate; health, hospital or medical services corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "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; 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. § 1395(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.

"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.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan.

"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. 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 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.

"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 disease, 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 Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. § 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible, and coinsurance for all services and supplies provided by network providers 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 services and

supplies provided by network providers for the remainder of the calendar year. If a carrier wishes to use a common maximum out of pocket provision in a plan that has both network and non-network benefits, the network maximum out of pocket shall mean the annual maximum dollar amount that a covered person must pay as copayment, deductible, and coinsurance for all services and supplies provided by network providers and non-network providers in a calendar year. All amounts paid as copayment, deductible, and coinsurance for both network and non-network services and supplies 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 services and supplies provided by network or non-network providers for the remainder of the calendar year.

"Non-network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as deductible and coinsurance for all services and supplies provided by non-network providers in a calendar year. All amounts paid as deductible and coinsurance shall count toward the non-network maximum out of pocket. 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 services and supplies provided by non-network providers for the remainder of the calendar year.

"Plan sponsor" has the meaning given that term under Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)).

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Public health plan" 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.

"Small employer" means:

1. In connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least one eligible employee on the first day of the plan year; or

2. In connection with a group health plan with respect to a calendar year and a plan year, an employer with a business location in the State of New Jersey who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year; and who employs at least one employee on the first day of the plan year.

With respect to 1 and 2 above, any person treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan issued to small employers pursuant to N.J.S.A. 17B:27A-19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

"State" means the State of New Jersey.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers 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 Small Employer Health Benefits 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.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

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.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Added "Non-standard health benefits plan" and "Standard health benefits plan"; and amended "Act", "Commissioner", "Department", "Eligible employee", "Federally-qualified HMO", "Health benefits plan", "Small employer", "Small employer carrier", "Small employer health benefits plan", "State approved HMO", "Stop loss", and "Supplemental limited benefit insurance".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

Amended "Dependent" and "Late enrollee"; added "Maximum out of pocket", "Network maximum out of pocket", and "Non-network maximum out of pocket".
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
In definition "Creditable coverage", inserted reference to "Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj)", inserted "a public health plan" and substituted "Federal" for "federal"; in definition "Enrollment date," added the last sentence; and added definition "Public health plan".
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
In definition "Dependent", inserted the second and third sentences; and in definition "Late enrollee", inserted "or dissolution of a civil union".
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Added definition "Allowed charge"; deleted definitions "Coinsurance cap" and "Coinsured charge limit"; and in definitions "Maximum out of pocket" and "Network maximum out of pocket", substituted "Except as provided in N.J.A.C. 11:22-5.2, all" for "All" throughout.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Added definitions "Affiliated company", "Carrier coinsurance", "Employee", "Employee open enrollment period", and "Employer open enrollment period"; deleted definitions "Church plan", "Creditable coverage", "Federally-qualified HMO", "Governmental plan", "Non-standard health benefits plan", "Preexisting condition exclusion", and "State approved HMO"; in definition "Coinsurance", inserted a comma following "copayment"; and rewrote definitions "Dependent", "Eligible employee", "Late enrollee", "Maximum out of pocket", "Network maximum out of pocket", and "Small employer".

11:21-1.3 Communications with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

New Jersey Small Employer Health Benefits
Program Board
20 West State Street, 11th Floor
PO Box 325
Trenton, New Jersey 08625-0325
Fax: (609) 633-2030
E-mail: ellen.derosa@dobi.state.nj.us

New Rule, R.1993 d.644, effective November 12, 1993.
See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Changed address and added fax number.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In the address, substituted "11th" for "10th".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In the address, inserted "E-mail: ellen.derosa@dobi.state.nj.us".

11:21-1.4 Penalties

Failure of a carrier to comply with any provision of this chapter shall result in the imposition of penalties as authorized by law, including, but not limited to, penalties set forth at N.J.S.A. 17B:27A-41 and 17B:27A-43.

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

11:21-1.5 Severability

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

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

11:21-1.6 Mission statement

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

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

11:21-2.1 Purpose and structure

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28) as amended to assure the availability of the five standardized health benefits plans to New Jersey small employers, their eligible employees and the dependents of those eligible employees, on a guaranteed issue basis.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Thereafter, all public members of the Board shall be elected or appointed for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. No carrier shall have more than one representative on the Board, nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital service corporation, or medical service corporation have more than one representative on the Board.

(f) The following categories shall be represented among the elected public members:

1. Three carriers whose principal health insurance business is in the small employer market;

2. One carrier whose principal health insurance business is in the larger employer market;

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

5. Three persons representing small employers, at least one of whom represents minority small employers.

(g) The following categories shall be represented among the appointed public members:

1. Two insurance producers licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq.;

2. One representative of organized labor;

3. One physician licensed to practice medicine and surgery in this State; and

4. Two persons who represent the general public and are not employees of a health benefits plan provider.

Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 27 N.J.R. 585(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a); in (e), inserted "Of the two elected members... term of two years."; in (f)1, increased number from two to three; in (f)4, increased number from one to two; deleted (f)5 and (f)6, providing for risk-assuming carriers and reinsuring carriers; and recodified (f)7 as (f)5.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted a reference to P.L. 1993, c.162, section 6; and in (e), added ", nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital insurance corporation, or medical service corporation have more than one representative on the Board" at the end.

11:21-2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2 or as further defined below:

"Administrator" or "Executive Director" means that person, persons, or entity selected by the Board to effectuate the administrative functions of the Program.

"Deferral" means a deferment, in whole or in part, of payments by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-38 and N.J.A.C. 11:21-15.

"Earned premiums" means the premium earned in New Jersey on health benefits plans less returned premiums thereon.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Reinsuring carrier" and "Risk-assuming carrier"; added "Non-standard health benefits plan", "Standard health benefits plan", and "Stop loss"; and amended "Board", "Commissioner", "Department", "Eligible employee", "Health benefits plan", "Member", "Small employer", "Small employer carrier", and "Small employer health benefits plan".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21-2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. Adopt rules and regulations to establish a voluntary risk pooling arrangement.

2. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

3. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

4. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the standard health benefits plans in accordance with applicable law;

5. Establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through the issuance of dual contracts to the small employer;

6. Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

7. Establish rules, conditions and procedures pertaining to the assessment of the members of the Program;

8. Establish a standard policy form for five standard health benefits plans and five rider packages, as provided in the Act;

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

10. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an Administrator or Executive Director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose advise or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and main-

tain such records of their activities as may be required by the Board.

11. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

12. Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

13. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

14. Develop a buyers' guide or other informational material for the Program, and provide for a reasonable charge for the use and distribution of such informational material.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted a reference to reimbursement in 8, and inserted references to other informational material in 15.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted 6 and recodified former 7 through 15 as 6 through 14.

11:21-2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21-2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. The Board shall be made up of the Commissioner, the Commissioner of Health and Senior Services, or their designees (who shall serve ex officio) and 16 public members. The composition of the Board shall be as described in N.J.S.A. 17B:27A-29 as amended. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in N.J.S.A. 17B:27A-29 as amended.

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

i. On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the 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.

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employers representatives nominated those persons that are eligible and willing to serve in the position for which nominated. Carriers may be placed on the ballot for only one 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 as to the single position for which it will accept the nomination, and be designated on the ballot.

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

iv. 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.

v. Elections shall be by the highest number of votes properly cast in person and absentee.

vi. 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. 11:21-2.11.

3. The Board may elect a Chair and Vice Chair from among its Directors, as well as other officers, as it deems

appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be on a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A-29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) A meeting of the Board shall be held no later than the first Tuesday in April each year in accordance with the State's Open Public Meetings Act.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program, as recommended by the Marketing and Communications Committee;

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Commissioner;

6. 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; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably comprehensive minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4-12). At least two copies of the minutes of each meeting of the Board shall be delivered forthwith to the Commissioner; delivery to the Commissioner's designee on the Board shall satisfy this requirement.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services but may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and committee meetings pursuant to the State Travel Guidelines issued by the Department of the Treasury.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(*l*) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

(m) The affirmative vote of at least two-thirds of the Directors present at a meeting shall be required to authorize assessments and the expenditure of Program funds.

Amended by R.1994 d.319, effective May 31, 1994.
See: 26 N.J.R. 1940(a), 26 N.J.R. 2587(a).
Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 26 N.J.R. 4311(a), 27 N.J.R. 585(a).
Amended by R.1995 d.223, effective May 1, 1995.
See: 27 N.J.R. 438(a), 27 N.J.R. 438(b), 27 N.J.R. 1805(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, amended title of Commissioner and inserted additional P.L. references; in (a)2, inserted "Of the two elected members ... term of two years."; in (a)2iv, added restriction on affiliated carrier Board membership; and in (b), amended titles of Commissioners.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted references to P.L. 1994, c.97 and P.L. 1995, c.298 in 1, added the second and third sentences in 2ii, and deleted a reference to Secretaries in the first sentence of 3; rewrote (d); in (e), substituted a reference to the Commissioner for a reference to the Legislature at the end of 5; and in (g), added "; delivery to the Commissioner's designee on the Board shall satisfy this requirement" at the end.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

In (a)2, amended N.J.A.C. reference; in (b), inserted "on" preceding "a one person" in the first sentence.

11:21-2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board. A written record of the proceedings of each committee shall be maintained by the Administrator or Executive Director. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and Audit Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;

iii. Independent consulting actuaries who may be approved by the Board;

iv. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and

v. Oversight of studies necessary for development of reinsurance mechanisms;

vi. The Plan amendments thereto;

vii. The selection of an independent auditor for the annual audit of the Program operations;

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

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

x. Developing the means to select a Program Administrator or Executive Director, a statement of the powers and duties of the Administrator or Executive Director, the compensation of the Administrator or Executive Director, and a statement of the efficiency standards an Administrator or Executive Director must meet; and

xi. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an Administrator or Executive Director for the Program;

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

i. Appropriate interpretations of the Act, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

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

vi. Maintenance of a written record of all written requests for a formal opinion of the Board received and responses provided by the Board.

vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;

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

ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and

x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;

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

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

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Legal Committee, Administrator, or Executive Director may seek the input of

other appropriate Committees in order to assist the Legal Committee in reaching a recommendation.

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

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 health benefits plans to eligible employees;

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

iii. Issues or concerns arising out of the marketing of Program coverage;

iv. The development of information concerning the Program to be released to the general public; and

v. Reviewing marketing material submitted by carriers in accordance with the Act; and

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

i. Optional benefit rider filings received pursuant to N.J.A.C. 11:21-3.2(d);

ii. Modifications to the standard health benefits plan policy forms and related forms;

iii. Interpretations of the standard health benefits plans and policy forms;

iv. Development of new standard health benefits plan policy forms as permitted by statute; and

v. Substantive and structural plan design issues.

(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:

1. Determine the size of and appoint members to and/or fill any vacancy in any committee;

2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;

3. Abolish any committees, in its discretion;

4. Remove any person from membership on any committee at any time, with or without cause; and

5. Authorize or appoint the use of consultants or other advisors to work with any committee.

(d) All committee members, including those committee members who are not also members of the Board, shall be subject to the Uniform Ethics Code pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq. Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and/or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Uniform Ethics Code and any Supplemental Code of Ethics the Board adopts.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), increased maximum number of directors on Standing Committees from five to seven and inserted text "who need not be directors" following "appoint additional members"; substantially amended (b); and added (d).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted a reference to the Administrator or Editorial Director for a reference to a Secretary at the end of the third sentence; in (b)1, deleted a former iii, recodified former iv through xii as iii through xi, and inserted references to the Executive Director throughout the new x and xi; in (b)2xi(2), inserted a reference to the Executive Director; and in (b)4ii, changed N.J.A.C. reference, and added a reference to Exhibit BB, Part 6 fillings at the end.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b)4, deleted ii and iii and recodified former iv through vii as ii through v.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In the introductory paragraph of (b)1, substituted "Audit" for "Operations"; and in (d), substituted the first occurrence of "Uniform Ethics Code" for "Small Employer Health Benefits Program Code of Ethics adopted by the Board" and "Uniform Ethics Code and any Supplemental Code of Ethics the Board adopts" for "Code of Ethics".

11:21-2.7 Administrator or Executive Director selection and duties

(a) The Administrator or Executive Director shall be selected by the Board.

(b) The Administrator or Executive Director shall perform the administrative functions required under the Act and the Plan. The Administrator or Executive Director is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.

(c) The Administrator or Executive Director shall perform all administrative functions developed by the Board including the following:

1. Preparing and submitting an annual report to the Board and the Commissioner no later than September 1;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program on a timely basis in the State Treasury in an account established for that purpose;

6. Issuing checks or drafts, on and or approving charges against bank accounts of the Program;

7. Keeping all accounting, administrative and financial records of the Program;

8. Acting as a resource for carriers in complying with the Program;

9. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

10. Preparing an annual estimate of the operating and administrative expenses of the Program; and

11. Performing other functions as agreed between the Board and the Administrator or Executive Director.

(d) The Administrator or Executive Director shall maintain calendar year records of premiums, reimbursements, and fiscal year operating and administrative expenses of the Program and shall retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq.

(e) The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Reworded (d)5; deleted (d)6, relating to reimbursing reinsuring carriers; recodified (d)7 through (d)12 as (d)6 through (d)11; in (d)8, deleted reference to reinsuring carrier; deleted (d)13, relating to reviewing for compliance; and recodified (d)14 as (d)12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Inserted references to the Executive Director throughout; deleted a former (b); recodified former (c) through (f) as (b) through (e); in the new (c), changed the deadline for the annual report from the third week in July to September 1 in 1, deleted a former 11, and recodified former 12 as 11; and in (d), substituted a reference to fiscal year operating and administrative expenses of the Program for a reference to operating and administrative expenses.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In (c)1, deleted "; preparing and submitting monthly reports to the Board" following "September 1".

11:21-2.8 Assessments for administrative and operating expenses

(a) Following approval of a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

3. Members shall be assessed for a proportionate share of the final administrative expenses for the fiscal year on the basis of health benefits plan earned premiums for the calendar year that includes the first six months of the fiscal year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the fiscal year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members of the calendar year that includes the first six months of the fiscal year.

i. Beginning in Fiscal Year 2005, if a member's proportionate share of the interim assessment or final administrative assessment is less than $5.00, the carrier shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

(c) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, SEH Program, and mailed to the Executive Director at the address in N.J.A.C. 11:21-1.3.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 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 as permitted by N.J.S.A. 17B:27A-32c.

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

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

iii. The interest so collected shall be applied in the assessment of the final administrative expenses as set forth in (a)3 above to reduce the liability of those members that were not subject to the payment of an interest penalty.

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

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21-15.

i. 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 to be held in an interest bearing account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The Administrator or Executive Director shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the Administrator or Executive Director until such time as the dispute has been settled against the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carrier within 15 days of the date that the Administrator or Executive Director receives notice of the determination by the Board or the Commissioner, as applicable along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator or Executive Director in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

(f) 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 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 or to take such other action against the carrier as may be authorized by law. 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.1997 d.62 effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), substituted "July 15" for "April 15".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph and 3; rewrote (c); and in (d) and (e), inserted references to the Executive Director throughout.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Added (a)3i; in (c), inserted an N.J.S.A. reference at the end of 1 and deleted "escrow" following "interest bearing" in 3i.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In the introductory paragraph of (a), substituted "Following approval of" for "Within 45 days after approving"; and added (c)1iii.

11:21-2.9 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act.

Recodified from 11:21-2.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Assessment for reimbursable losses".

11:21-2.10 Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

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

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

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

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Any adjustments to assessments as explained in this Plan;

ii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

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

iv. Other records required by the Board.

5. The Board shall maintain a general ledger which balances are used to produce the 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 ledgers or journals.

6. The Board's fiscal year shall begin on July 1 and end on June 30.

7. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of Director of the Division of Budget and Accounting to the Program's bank accounts upon request by the Board through the Department.

3. The Administrator or Executive Director shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) A bank checking account and interest-bearing investment accounts shall be established separately in the name of the Program and shall be approved by the Board.

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

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program administrative expenses.

Recodified from 11:21-2.11 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)4i, relating to net losses; recodified former (a)4ii through (a)4v as (a)4i through (a)4iv; inserted new (a)6; recodified former (a)6 as (a)7; in (b)2, deleted reference to including in the request justification for the request; and in (c), inserted reference to interest-bearing investment. Former section recodified to N.J.A.C. 11:21-2.9.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b)3, inserted a reference to the Executive Director; and in (c)2, deleted a reference to Program losses in the last sentence.

11:21-2.11 Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3-15-32) and all other applicable laws.

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

1. Minutes of all Board meetings;

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

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. Riders 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. Regulations or actions proposed or adopted by the Board, including all comments received; and

8. 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 the 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 com-

munications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection and copying.

Recodified from 11:21-2.12 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-2.10.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (c).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (d).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In (c), deleted "the 'Right-to-Know' Law (" preceding and the closing parenthesis following "N.J.S.A. 47:1A-1 et seq."

11:21-2.12 Audit functions

(a) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program; and

2. The annual fiscal report of the Program.

Recodified from 11:21-2.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a), relating to necessity and frequency of audits; recodified former (b) as (a); deleted (a)3, relating to calculation and collection of assessments for net losses. Former section recodified to N.J.A.C. 11:21-2.11.

11:21-2.13 Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board consistent with the appeals procedures set forth at N.J.A.C. 11:21-2.17.

Recodified from 11:21-2.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-2.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (e), substituted a reference to 45 days for a reference to 30 days in the first sentence.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (c); deleted (d) and (e).

11:21-2.14 Indemnification

(a) A member or employee of the Board, including the Administrator or Executive Director and staff, shall not be liable in an action for damages to any person for any action taken or recommendation made by him or her within the scope of his or her functions as a member or employee, if the action or recommendation was taken or made without malice.

(b) The members of the Board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L. 1972, c.45, on account of acts or omissions in the scope of their employment.

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-2.13.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director.

11:21-2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent

by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

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

Recodified from 11:21-2.16 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Indemnification".

11:21-2.16 (Reserved)

Recodified to 11:21-2.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

11:21-2.17 Appeals

(a) If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Board's determination within 20 days from the date of receipt of such determination as follows:

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

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

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are material issues of fact in dispute.

3. The Board shall, within 45 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 Board finds that the matter constitutes a contested case, it shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. In a matter which has been determined to be a contested case, if the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

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

1. Plan B, "The Small Group Health Benefits Policy B," Exhibits F and W featuring carrier coinsurance of 50 percent or 60 percent;

2. Plan C, "The Small Group Health Benefits Policy C," Exhibits F and W featuring carrier coinsurance of 70 percent;

3. Plan D, "The Small Group Health Benefits Policy D," Exhibits F and W featuring carrier coinsurance of 80 percent;

4. Plan E, "The Small Group Health Benefits Policy E," Exhibits F and W featuring carrier coinsurance of 90 percent;

5. Exhibit F contains those items of Plans B, C, D, and E which are common among the plans as well as text which is unique to Plans B, C, D, and E, where such Plan unique text is clearly identified;

6. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibits G and Y; and

7. HMO-POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibits HH and II.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer at least three of the health benefits plans designated as Plans B, C, D, and E as set forth in Exhibits V and W, in the Appendix, subject to (b)1 and 2 below and except as set forth in (c) below.

1. Plans B, C, D, and/or E may be offered. Members offering these plans shall include annual deductible provisions consistent with the following specifications:

i. The per covered person annual deductible may not exceed the maximum deductible permitted by 45 CFR 156.130.

ii. The per covered family annual deductible shall be two times the per covered person annual deductible, satisfied on an aggregate basis.

2. Members offering Plans B, C, D, and/or E shall include maximum out of pocket provisions such that the maximum out of pocket amount shall not exceed the annual limitation on cost sharing specified in 45 CFR 156.130 for both self-only and other than self-only coverage.

(c) HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of at least three of the plans designated as Plans B through E in (a) above. HMO members offering the HMO Plan shall offer one or more of the following plan designs using copayments and may, at the option of the HMO members, also offer HMO plans using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every small employer 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. Copayment Design:

i. The hospital inpatient copayment shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, and prescription drugs shall be consistent with N.J.A.C. 11:22-5.5(a).

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, or pre-natal care shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130. The covered family deductible shall be two times the per person deductible satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies, shall be a percentage between 10 percent and 50 percent, inclusive.

iv. The maximum out of pocket shall be a dollar amount, which shall not exceed the annual limitation on cost sharing set forth at 45 CFR 156.130, and the maximum out of pocket for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible, and coinsurance, shall not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).

ii. Pre-natal care shall be covered without cost sharing.

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to deductible and/or coinsurance, or copayment(s) consistent with N.J.A.C. 11:22-5.5(a).

(d) The standard health benefits Plans B, C, D, and E and optional riders may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c.162, section 22 (N.J.S.A. 17B:27A-54). The standard health benefits Plans B, C, D, and E and optional riders may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements shall be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6 and 11:22-5;

2. The network annual deductible shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130 and for a covered family shall not exceed 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 network maximum out of pocket shall not exceed the annual limitation on cost sharing set forth at 45 CFR 156.130 and for a covered family shall not exceed two times the per covered person maximum out of pocket. 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;

4. The non-network annual deductible shall be no more than three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible;

5. The non-network maximum out of pocket shall be no more than 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; and

6. The HMO Plan standard copayment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to network benefits.

(e) An insurer with an approved selective contracting agreement, like all other carriers, shall offer at least three of the standard health benefits plans, whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

1. If an insurer's approved service area for its selective contracting arrangement includes all geographic areas in the State, the insurer shall offer at least three of the standard health benefits plans as either indemnity plans or through or in conjunction with a selective contracting arrangement, or both, in all geographic areas in the State.

2. If an insurer's approved service area for its selective contracting arrangement does not include all geographic areas in the State, the insurer shall offer:

i. At least three of the standard health benefits plans as indemnity plans in all areas in the State not included in its approved service area; and

ii. At least three of the standard health benefit plans as either indemnity plans or in conjunction with a selective contracting arrangement, or both, in all geographic areas within its approved service area.

3. If an insurer with a limited approved service area chooses to offer at least three of the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(f) A carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute shall offer the standard health benefits plans whether as indemnity plans or as PPO, POS, or EPO plans in all geographic areas of the State.

1. If such a carrier has agreements with participating providers in all geographic areas of the State, the carrier shall offer the standard health benefits plans either as indemnity plans or as PPO, POS, or EPO plans or any such combination in all geographic areas of the State.

2. If such a carrier has agreements with participating providers only in certain geographic areas of the State, the carrier shall offer:

i. The standard health benefits plans as indemnity plans in all geographic areas of the State where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO, POS, or EPO plans or any such combination in all geographic areas of the State where it has agreements with participating providers.

3. If such a carrier which has agreements with participating providers only in certain geographic areas of the State chooses to offer the standard health benefits plans only as PPO, POS, or EPO plans in such areas and later expands the area in which it has agreements with providers, the carrier shall not be required to offer the standard health benefits plans as indemnity plans in the expanded area, but shall be required to renew the in force standard health benefits plans in the newly expanded area.

(g) HMO members may offer the HMO POS plan, as set forth in Exhibit HH of the Appendix, so long as the member is in compliance with N.J.A.C. 8:38-14, which regulations set forth requirements for HMOs offering indemnity benefits. HMO members offering the HMO POS plan may offer the following arrangements set forth in (g)1, 2, and 3 below with respect to their network services and supplies. The non-network deductible, coinsurance and maximum out of pocket must comply with N.J.A.C. 11:21-3.1(d).

1. Copayment Design:

i. The hospital inpatient copayment shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, and prescription drugs shall be consistent with N.J.A.C. 11:22-5.5(a).

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, or pre-natal care shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130. The covered family deductible shall be two times the per person deductible satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed the maximum out of pocket shall not exceed the annual limitation on cost sharing set forth at 45 CFR 156.130, and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).

ii. Pre-natal care shall be covered without cost sharing.

iii. Prescription drugs covered under the HMO-POS plan, as opposed to under a separate prescription drug rider, shall be subject to deductible and/or coinsurance or copayment(s) consistent with N.J.A.C. 11:22-5.5(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.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), (d), and (e), substituted "standard health benefits plan" for "small employer health benefits plan"; added (a)8; in (d), deleted reference to HMO Plan; in (d)3, deleted reference to out-network benefits; and added (f) through (h).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), changed Exhibit references throughout, and added "as well as text which is unique to Plans B, C, D and E, where such Plan unique text is clearly identified" at the end of 6; in (b), substituted a reference to Exhibits A, F, V and W for a reference to Exhibits A through F in the introductory paragraph; and in (d), rewrote the introductory paragraph and 1, and substituted a reference to Exhibits F and G for a reference to Exhibits B through G in 2.
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
In (b), inserted a new 3, and recodified former 3 as 4; inserted (c)4; and in (h), substituted "non-biologically based mental illness" for "mental/nervous and substance abuse" following "$200.00" in 4, and added 5.
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (b) through (d); in (e), added 3 and 4; rewrote (h).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Rewrote (b); in the introductory paragraph of (c), inserted "of at least three of the plans designated as"; in (c)2iv, (d)3 and (e)3, substituted "$7,500" for "$5,000"; in (d)1, inserted "and 11:22-5"; in the introductory paragraph of (f), (f)1 and (f)3, inserted "at least three of"; in the introductory paragraph of (f), inserted "where one plan is Plan A"; in (f)1, (f)2i and (f)2ii, inserted "provided that one of the plans offered is Plan A"; and in (f)2i and (f)2ii, substituted "At least three of the" for "The".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Rewrote the section.

11:21-3.2 Optional benefit riders to standard plans and administrative functions

(a) Members may offer riders that revise in any way the coverage offered by Plans B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (a)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner.

2. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. "Coverage" offered by the four plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (a)2 above includes, but is not limited to:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations," and "Exclusions" sections of Plans B, C, D, and E the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan, and the "Covered Services and Supplies," "Covered Charges," "Covered Charges with Special Limitations," and "Non-Covered Services and Supplies and Non-Covered Charges" sections of the HMO POS plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent coverage," and "Continuation rights" sections of Plans B, C, D, and E, the "Eligibility" and

"Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

4. "Coverage" offered by the four plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (a)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:21-1.2, except for dental coverage for persons age 19 or older where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:21-1.2.

5. In addition to (a)1, 2, 3, and 4 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9, and 11 of P.L. 1992, c.162, as amended.

6. A member making an informational filing to the Board pursuant to (a)2 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21-1.3 through paper or electronic means;

ii. Submit one copy of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross-references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans B, C, D, E, HMO, or HMO POS plan and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard group policy and employee certificate language shall not be altered, and the benefit modifications shall appear only on the rider or riders; and

v. For riders of increasing value only, submit copies of a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan B, C, D, E, HMO, or HMO POS;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any small employer seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:21-9;

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the HMO POS contract, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and 8:38-14.4(c), as applicable; and

(6) That the premium or percentage change for a ridered standard plan shall be listed separately from the premium or percentage change for the unridered standard plan when rates are illustrated on rate quotes prepared by the carrier.

7. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with this subsection, within 60 days of the Board's receipt of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 60 days of the Board's receipt of the submission, the informational filing shall be deemed complete.

i. If an informational filing is incomplete and not in compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is complete.

ii. If the Board takes no action within 60 days of receipt by the Board of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be complete.

(b) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such

arrangements shall not alter the standard group policy and certificate language.

(c) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit riders. Carriers shall include in such filing information that is current through December 31 of the prior year.

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1995 d.116, effective March 6, 1995.
See: 26 N.J.R. 4729(a), 27 N.J.R. 918(a).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted "standard" preceding "optional benefits riders" and inserted reference to HMO POS throughout; in (a), inserted "standard" preceding "health benefits plan"; in (d)3i, added text "and the 'Covered Services and Supplies,' ... HMO POS plan"; in (d)3iii, inserted reference to Eligibility and Continuation Rights sections of the HMO POS plan; in (d)4ii and (d)5, deleted reference to vision coverage and benefits; in (d)7i, amended submission requirements and added (d)7vi(5).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (d), deleted a reference N.J.A.C. 11:21-12 in 1, deleted a former 5, recodified former 6 through 8 as 5 through 7 and made a corresponding internal reference change, added "For riders of increasing value only," at the beginning of vi and deleted "plan not approved by the Commissioner" at the end of vi(1) in the new 6; and added (f).
Amended by R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(a).
Rewrote (c).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), inserted ", or HMO POS plan" preceding "as applicable"; in (d), rewrote 3ii, deleted "an original" preceding "one copy" in 6i, substituted "one copy" for "copies" preceding "of the rider" in 6ii and rewrote 7; in (f), added the last sentence.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In (a), substituted "and/or" for "and" following the first occurrence of "D"; in (d)6vi(4), deleted "and" from the end; in (d)6iv(5), deleted "N.J.A.C." preceding "8:38-14.4(c)" and substituted "; and" for a period at the end; added (d)6vi(6); and in the introductory paragraph of (d)7 and (d)7ii, substituted "60" for "45" throughout.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Rewrote the section.

SUBCHAPTER 3A. (RESERVED)

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference. Members shall not make any changes to the text of the standard policy forms, except as permitted consistent with the explanation of brackets set forth as Exhibit K.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G and Y, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(c) Members shall use the standard policy form for HMO-POS plan which is set forth in the Appendix to this chapter as Exhibit HH and II, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(d) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

(e) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(f) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(g) Members shall use the standard employee evidence of coverage for the HMO POS plan which is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(h) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

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.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted new (c); recodified former (c) through (g) as (d) through (h); in (d), inserted text "standard optional benefit"; added (i); and recodified former (h) through (j) as (j) through (*l*).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph, and deleted "in triplicate" following "review" in 1i; in (b), inserted a reference to Exhibit Y in the introductory paragraph; and in (c), inserted a reference to Exhibit II in the introductory paragraph.

Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In (a), deleted "A," following "Plans" and following "Exhibits"; deleted former (d); recodified former (e) as (d); deleted former (f); recodified former (g) through (i) as (e) through (g); deleted former (j); and recodified former (k) as (h).

11:21-4.2 Certification or filing of forms

(a) No carrier shall issue any health benefits plan certificate or evidence of coverage to a small employer or the employees of a small employer or use any application form, employer or employee certification, waiver or enrollment form or make any amendments thereto until the carrier has certified that its health benefits plans and forms are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21-4 and 6.

1. A carrier shall submit completed Certification of Compliance forms, set forth in Parts 1, 2 and 6 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference upon entering the small employer market, on or before 45 days of the date amendments to the standard policy forms are effective, and on or before March 1 of each year thereafter. The market entry filing and the filing upon amendments being made to the standard policy forms shall address the plans the carrier will be marketing and issuing. The March 1 filing shall address the plans the carrier issued or renewed at anytime during the prior calendar year.

2. A carrier shall submit completed Certification of Compliance forms to the Board, at the address set forth at N.J.A.C. 11:21-1.3.

3. Certification of Compliance forms shall be certified by a duly authorized officer of the carrier.

(b) Carriers that submit Certification of Compliance forms may issue and make effective small employer health benefits plans upon filing such forms with the Board and the Commissioner, and may continue to do so until such time as the filing is disapproved in writing by the Board (in consultation with the Commissioner), following an opportunity for a hearing held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and any rules promulgated thereunder.

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (a)2, and (c), amended submission requirements.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to Part 6 of Exhibit BB in 1, and rewrote 2; in (b), deleted "with copies submitted to the Commissioner as set forth in (a)2 above" at the end; in (e), deleted "or January 1, 1994, whichever is later" following "Commissioner"; in (g)1, deleted "in triplicate" following "submitted"; and added (h).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), rewrote 1; deleted former (b) through (d) and recodified former (e) as (b); deleted former (f) and recodified former (g) and (h) as (c) and (d).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Deleted (c) and (d).

11:21-4.3 (Reserved)

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted former 4, recodified former 5 as 4, and deleted references to alternative methods of utilization review throughout; in (b), deleted "an alternative method of utilization review or" preceding "combined forms".
Repealed by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Section was "Standards for review".

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans B, C, D, E, HMO, and HMO POS through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. If expressly permitted by the Board, the Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms Plans B-E, HMO, and HMO POS contracts, certificates, or evidences of coverage. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans B-E, HMO, or HMO POS contract, certificate, or evidence of coverage which has incorporated Board promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans B, C, D, E, HMO, and HMO POS consistent with the variability as explained in Exhibit K to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by (a) and (b) above. In no event shall the Compliance and Variability Rider be used in lieu of optional benefit riders which riders are subject to filing requirements set forth in N.J.A.C. 11:21-3.2(d).

New Rule, R.1995 d.312, effective June 19, 1995.
See: 27 N.J.R. 439(a), 27 N.J.R. 2407(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Inserted references to HMO POS contracts throughout.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a)1, added "If expressly permitted by the Board," at the beginning, and inserted references to Plans A through E throughout; and in (b), inserted a reference to Exhibit JJ.
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), deleted "and JJ" preceding "to this Appendix".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In the introductory paragraph of (a) and in (b), deleted "A," following "Plans"; in the introductory paragraph of (a), deleted "and for the standard riders promulgated by the Board," following the second occurrence of "POS"; in (a)1, substituted "B-E, HMO," for "A-E, HMO", inserted "or" preceding "evidences" and preceding "evidence", and deleted ", or standard riders promulgated by the Board" following the first occurrence of "coverage" and "or standard rider" following the second occurrence of "coverage"; and in (b), deleted "and for the standard riders promulgated by the Board" following the second occurrence of "POS".

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. STANDARD EMPLOYER AND EMPLOYEE APPLICATION AND SMALL EMPLOYER CERTIFICATION FORMS

11:21-6.1 Standard application form

(a) All small employer carriers offering small employer health benefits plans with an effective date on or after January 1, 1994, shall use the standard application form approved by the Board and available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html.

(b) Small employer carriers shall require any small employer applying for a small employer health benefits plan to be issued by that small employer carrier to complete, as part of the application, the New Jersey Small Employer Certification form approved by the Board and available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html.

(c) The application requires the following types of information:

1. The policyholder name and contact information;
2. The Federal Tax ID Number;
3. The type of business and nature of the business;
4. The number of employees, classes of employees, and coverage type;
5. The status with respect to COBRA and Medicare as secondary payor;
6. The waiting period;
7. The contribution percentage;
8. Affiliates;
9. Benefit options;
10. Replacement information;
11. Continued coverage;
12. Agent/producer information; and
13. A signature section.

(d) The certification requires the following types of information:

1. The status as small employer;
2. Work locations;
3. The participation calculation;
4. The application of Federal laws; and
5. The certification signature.

Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In (a), substituted "and available on the Board's website at www.state.nj.us/dobi/devision_insurance/ihcseh/sehforms.html" for "and specified in Exhibit N of the Appendix to this chapter incorporated herein by reference"; in (b), substituted "and available on the Board's website at www.state.nj.us/dobi/devision_insurance/ihcseh/sehforms.html" for "and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference"; and added (c) and (d).
Administrative correction.
See: 46 N.J.R. 300(a).

11:21-6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. This form shall be sent to the small employer for completion no earlier than 150 days prior to the renewal of the small employer's health benefits plan. The information requested on the certification form is set forth at N.J.A.C. 11:21-6.1(d).

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Substituted "150" for "120" in the last sentence.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Substituted "and available on the Board's website at www.state.nj.us/dobi/devision_insurance/ihcseh/sehforms.html" for "and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference"; and inserted the last sentence.
Administrative correction.
See: 46 N.J.R. 300(a).

11:21-6.3 (Reserved)

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted reference to HMO POS plan.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b), substituted a reference to Exhibit Q for a reference to Exhibit R in the first sentence; and in (c), substituted "as optional text in Exhibit Q" for "in Exhibit S" in the second sentence of the introductory paragraph, and deleted "Beginning on September 11, 1994," at the beginning of 1.
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Enrollment".

11:21-6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference.

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted the last sentence.

SUBCHAPTER 7. PROGRAM COMPLIANCE

11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted "on or after January 1, 1994" at the end of the section.

11:21-7.2 Determination of small employer status

(a) To determine whether an employer qualifies as a small employer, as defined in N.J.A.C. 11:21-1.2, a carrier shall evaluate whether an employer satisfies the requirements in either paragraph 1 or 2 of the definition. If the employer satisfies either paragraph 1 or 2, then the employer shall be considered to be a small employer.

(b) With respect to paragraph 1 of the definition of small employer, a small employer carrier shall include all persons who meet the definition of eligible employee.

1. The small employer carrier shall include all full-time bona-fide employees who work 25 or more hours per week.

(c) With respect to paragraph 2 of the definition of small employer, a small employer carrier shall add the number of full-time employees to the number that results from the part-time employee calculation, and if the sum is at least one but not more than 50, the employer shall be considered to be a small employer.

1. Employees working 30 or more hours per week are full-time employees and each full-time employee counts as one.

2. Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by four and the product divided by 120 and rounded down to the nearest whole number.

3. Small employer carriers shall not include sole proprietors, partners of partnerships, or two percent or more owners of Subchapter S corporations, or their immediate family members as employees in (c)1 or 2 above even if such persons will be covered under the employer's plan.

(d) Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L. 1992, c. 162 (N.J.S.A. 17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition.

(e) In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on:

1. The average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year with respect to small employers that meets paragraph 1 of the definition of small employer; or

2. The average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year with respect to small employers that meets paragraph 2 of the definition of small employer.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Health benefits plan" and "Standard health benefits plan"; and added "Qualifying previous coverage".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended "Late enrollee".
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
In definition "Creditable coverage", inserted reference to "Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj)", and inserted "a public health plan"; in definition "Enrollment date", added the last sentence; and added definition "Public health plan".
Repeal and New Rule, R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Definitions".

11:21-7.3 Eligibility and issuance

(a) A small employer carrier shall issue a health benefits plan to any small employer which requests it, pays the premiums therefor, and meets the contribution and participation requirements, if any, of the small employer carrier. All health benefits plans shall provide coverage for all eligible employees and their dependents who elect to participate regardless of health status-related factors and without exclusionary riders.

1. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographical location of the employees of the small employer, except that an HMO carrier or other carrier issuing a network-based plan may refuse to issue coverage to an employer to cover an employee that does not live, work, or reside in the small employer carrier's service area.

2. Every small employer carrier except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers at least three of standard health benefits Plans B, C, D, and E, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to small employers every standard health benefits plan it writes, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans.

3. A small employer carrier shall consider the number of all eligible employees of all affiliated companies of a small employer in determining whether an employer is a small employer and in determining participation levels.

4. At the time of application, the determination of whether an employer is a small employer shall be based upon the small employer's completed New Jersey Small Employer Certification form.

i. If an employer qualifies as a small employer in the immediately preceding calendar year, the employer shall be considered a small employer regardless of the status of the employer on the date of application or the effective date of coverage so long as it employs:

(1) At least one eligible employee on the first day of the plan year with respect to a small employer that satisfies paragraph 1 of the definition of small employer in N.J.A.C. 11:21-1.2; or

(2) At least one employee on the first day of the plan year with respect to a small employer that satisfies paragraph 2 of the definition of small employer in N.J.A.C. 11:21-1.2.

ii. If an employer did not qualify as a small employer in the immediately preceding calendar year, the employer shall not be considered a small employer, regardless of the status of the employer on the date of application or the proposed effective date of coverage, if any.

iii. In the case of an employer that was not in existence during the preceding calendar year, refer to N.J.A.C. 11:21-7.2(e).

(b) A small employer carrier shall issue only standard health benefits plans to an association, trust, or multiple employer arrangement to provide coverage to member small employers.

1. No carrier shall issue a health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every health benefits plan issued to the association.

(c) Employees who enroll within 30 days of first becoming eligible for coverage shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to their risk characteristics or that of their dependents. Employees who are late enrollees shall be accepted for coverage by the small employer carrier if enrollment is requested during the employee open enrollment period.

(d) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a); in (b), amended N.J.A.C. reference; and in (e), (f), and (g), substituted P.L. reference for N.J.A.C references.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted a reference to health status-related factors for a reference to health in the introductory paragraph, substituted references to calendar years for references to calendar quarters throughout 5, added "so long as it employs at least two employees on the first day of the plan year" at the end of 5i, deleted ", except as set forth in (iii) below" at the end of 5ii, and rewrote 5iii; and in (d), added the second and third sentences.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (a) and added (h).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In (a)2, deleted "the five" preceding the first occurrence of "standard" and substituted "Plan A and at least two of standard health benefits Plans B, C, D and E" for the first occurrence of "plans"; deleted former (c)2; recodified former (c)3 through (c)5 as (c)2 through (c)4; in (c)3, deleted

"and" from the end; in (c)4, substituted "; and" for a period at the end; and added (c)5.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Rewrote the section.

11:21-7.4 Limitations on purchase by small employers of health benefits plans or riders with different actuarial value than existing plan

(a) A small employer who purchases a health benefits plan or rider pursuant to the Act shall not be permitted to purchase a health benefits plan or rider with a greater actuarial value until the first anniversary date of the small employer's existing health benefits plan.

(b) When a small employer replaces a health benefits plan or rider with a health benefits plan or rider of greater actuarial value, the small employer shall not be permitted to change the health benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's health benefits plan.

(c) A small employer who has purchased a health benefits plan or rider pursuant to the Act may purchase a health benefits plan or rider of lesser actuarial value prior to the anniversary date of the existing health benefits plan or rider, provided that the existing health benefits plan or rider was purchased at least 12 months prior to the latest anniversary date of the health benefits plan or rider.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.5 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "standard" "preceding health benefits plan" throughout. Section was "Carriers acting as administrators for small employers".
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (d).

11:21-7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(d), except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who:

1. Is covered as an employee or dependent under any fully insured health benefits plan offered by the small employer;

2. Is covered under Medicare;

3. Is covered under Medicaid or NJ FamilyCare;

4. Is covered under another group health benefits plan;

5. Is covered under a spouse's group health benefits plan; or

6. Is covered under Tricare.

(b) A small employer carrier may, upon approval by the Board, require a minimum participation of less than 75 percent provided that the small employer carrier:

1. Notifies the Board in writing of its minimum requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser participation requirements, in accordance with procedures established by the Board in its Plan of Operation.

(e) A small employer carrier shall not require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees with respect to employer applications received during the employer annual open enrollment period.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Recodified from 11:21-7.6 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a). Former section recodified to N.J.A.C. 11:21-7.4.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted "who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(c)," in the first sentence of the introductory paragraph, inserted "as an employee or dependent" in 1, and substituted a reference to creditable coverage for a reference to qualifying previous coverage at the end of 2.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), inserted "fully insured" preceding "health benefits" in 1, rewrote 2 and added 3 and 4.
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Inserted new (a)3. and recodified previous (a)3. and (a)4. as (a)4. and (a)5.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
In (a)5, inserted "group".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In the introductory paragraph of (a), updated the N.J.A.C. reference; in (a)4, deleted "or" from the end; in (a)5, substituted "; or" for a period at the end; and added (a)6 and (e).

11:21-7.6 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers.

(b) A small employer carrier may, upon approval of the Board, require a minimum contribution of less than 10 percent provided that the small employer carrier:

1. Notifies the Board in writing of its contribution requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser contribution requirements, in accordance with procedures established by the Board in its Plan of Operation.

(e) A small employer carrier shall not require any minimum contribution toward the annual cost of the small employer's health benefits plan with respect to employer applications received during the employer annual open enrollment period.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.7 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.5.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Added (e).
Administrative correction.
See: 47 N.J.R. 724(a).

11:21-7.7 Employee open enrollment period

(a) Each small employer shall designate a 30-day period each year as the employee open enrollment period. Such period shall begin no more than 90 days prior to the start of the plan year.

(b) Employees and dependents who are eligible under the small employer's plan but who are late enrollees may enroll for coverage under the small employer's plan during the employee open enrollment period.

(c) Employees and dependents who are covered under the small employer's plan who wish to elect coverage under a different policy, if any, offered by the small employer, may enroll for coverage under the alternate plan during the employee open enrollment period.

(d) The effective date of coverage applied for during the employer open enrollment period shall be the start of the plan year.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.8 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.6.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Repeal and New Rule, R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Preexisting condition standards".

11:21-7.7A Special enrollment period

(a) The special enrollment period means a period of time that is no less than 30 days following the date of a triggering event listed in (b)1 through 5 below and no less than 60 days following a triggering event listed in (b)6 below during which:

1. Eligible employees and dependents who are late enrollees are permitted to enroll under the small employer's plan; and

2. Eligible employees and dependents who already have coverage are allowed to replace current coverage with a different plan, if any, offered by the small employer.

(b) Triggering events are:

1. The date an eligible employee or dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a triggering event;

2. The date an eligible employee acquires a dependent or becomes a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

3. The date an eligible employee's enrollment or nonenrollment in a qualified health plan is the result of error, misrepresentation, or inaction by the Federal government;

4. The date an eligible employee or eligible dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

5. The date the eligible employee or dependent gains access to new qualified health plans as a result of a permanent move; and

6. The date the eligible employee or dependent loses or gains eligibility under Medicaid or NJFamilyCare.

(c) The effective date of the employee's coverage or dependent's coverage shall be:

1. The day after the loss of minimum essential coverage as described in (b)1 above;

2. The date of marriage, birth, adoption, placement for adoption, or placement in foster care as described in (b)2 above; or

3. The first of the month following receipt of the enrollment form with respect to the events described in (b)3, 4, 5, and 6 above.

(d) If an eligible employee initially waived coverage and stated at that time that such waiver was because he or she was covered under another group plan, and the employee subsequently elects to enroll under the small employer's plan, the employee and his or her dependents will not be late enrollees.

1. The employee may enroll under the small employer's plan within 90 days of the date any of the events described in (d)2 below occurs. The small employer carrier will assign an effective date as of the day after the event described in (d)2 below occurs.

2. The employee is not considered to be a late enrollee if the coverage under the other plan ends due to one of the following events:

i. Termination of employment or eligibility;

ii. Reduction in the number of hours of employment;

iii. Involuntary termination;

iv. Divorce or legal separation or dissolution of the civil union or termination of the domestic partnership;

v. Death of the eligible employee's spouse;

vi. Termination of the policyholder's contribution toward coverage; or

vii. Termination of the other plan's coverage.

(e) The eligible employee must enroll within 90 days of the date that any of the events described in (d) above occur. Coverage will take effect as of the date the applicable event occurs.

New Rule, R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).

11:21-7.8 Effective date of employer's coverage

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

1. A completed small employer standard application form including the small employer certification form in accordance with N.J.A.C. 11:21-6.1(a) and (b);

2. Complete employee enrollment forms and waiver forms; and

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

(b) A small employer carrier shall provide notice to the employer within 15 working days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employer's application for the health benefits plan. Except as stated in (c) below, if approved, the effective date of coverage under the health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c) The effective date of coverage under a health benefits plan issued to an employer as a result of an application received during the employer annual open enrollment period shall be January 1 of the year following the employer annual open enrollment period.

(d) At the option and upon the request of the small employer, a waiting period may be applied by the small employer carrier with respect to employees when they first become eligible for coverage, not to exceed 90 days. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(e) A small employer carrier may offer an automatic checking withdrawal option to small employer groups for the monthly or quarterly payment of premiums. In the event that a small employer carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all small employer groups, regardless of the size of the group or the type of health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.9 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.7.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a)2, substituted "forms and waiver forms" for the N.J.A.C. reference.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Effective date of coverage". In (a)3, deleted "except as provided in N.J.A.C. 11:21-7.5(d)2," preceding "which"; in (b), substituted "Except as stated in (c) below, if" for "If"; added new (c); recodified former (c) and (d) as (d) and (e); in (d), substituted "90 days" for "six months"; and deleted former (e).

11:21-7.9 Price quotes; disclosures

(a) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized third party, within 10 working days of receiving a request for a quote and such information as is reasonable and necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five working days of receiving a request for a price

quote of any additional information needed by the small employer carrier to provide the quote.

(b) Each small employer carrier shall make reasonable disclosure in price quotes provided to small employers of the provisions concerning the small employer carrier's right to change premiums and the criteria in the small employer carrier's rate filing which affect changes in premium rates.

Recodified from 11:21-7.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.8.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), substituted "third party" for "producer" following "authorized".

11:21-7.10 Tie-ins

A small employer carrier shall not require, as a condition to the offer or sale of a health benefits plan to a small employer, that the small employer purchase or qualify for any other insurance products or services.

Recodified from 11:21-7.11 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.9.

11:21-7.11 Guaranteed renewal

(a) All health benefits plans that are issued or renewed on or after January 1, 1994, must be guaranteed renewable at the option of the policy or contract holder or small employer, except that a carrier may discontinue a health benefits plan pursuant to (b) below or nonrenew a health benefits pursuant to (c) below.

(b) A carrier may discontinue a health benefits plan only if:

1. The policyholder, contract holder, or employer has failed to pay premiums or contributions in accordance with the terms of the health benefits plan or the carrier has not received timely premium payments; or

2. The policyholder, contract holder, or employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(c) A carrier may nonrenew a health benefits plan only if:

1. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy or contract unless renewal coincides with an employer open enrollment period. Minimum participation rates are calculated once per year at the time of initial group submission and subsequently at the time of renewal;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements unless renewal coincides with an employer open enrollment period. Minimum contribution rates are calculated once per year at the time of initial group submission and subsequently at the time of renewal;

3. The carrier files with the Commissioner to withdraw from the small employer market and meets the requirements of N.J.A.C. 11:21-16;

4. The small employer ceases its membership in an association or trust of employers where the health benefits plan was issued in connection with such membership;

5. The carrier receives approval to cease offering and renewing a particular type of a plan and meets the requirements of N.J.A.C. 11:21-13;

6. The SEH Board discontinues a particular standard health benefits plan or plan option; or

7. In the case of a health maintenance organization plan issued to a small employer:

i. An eligible person who no longer resides, lives, or works in the carrier's approved service area, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

ii. A small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to N.J.S.A. 17B:27A-26.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.12 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)6, relating to coverage for less than two employees; recodified (a)7 and (a)8 as (a)6 and (a)7; and added (b). Former section recodified to N.J.A.C. 11:21-7.10.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In (c)1 and (c)2, inserted "unless renewal coincides with an employer open enrollment period" and the last sentence.

11:21-7.12 Reporting requirements

(a) A small employer carrier shall file with the Board, quarterly no later than 60 days after the end of the fiscal quarter, the following information reported with respect to standard health benefits plans:

1. The number of small employers, covered employees, and dependents that were issued health benefits plans in the previous calendar quarter, reported separately as to newly issued plans and renewals, and separately for standard health benefits plans B, C, D, and E; plans B, C, D, and E sold through or in conjunction with a selective contracting arrangement; HMO; and HMO POS; and

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately for each standard health benefits plan B, C, D, and E; plans B, C, D, and E sold through or in conjunction with a selective contracting arrangement; HMO; and HMO POS.

(b) Quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

(c) An insurance company, health service corporation, hospital service corporation, or medical service corporation and affiliated health maintenance organization shall file separate reports.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (b)1, and (b)2, inserted reference to plans sold through selective contracting and to HMO POS; in (a)2, substituted reference to geographic territory for reference to three digit zip code and amended N.J.A.C. reference; and added (d) and (e).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b), deleted "Effective on the fiscal quarter ending on September 30, 1994," at the beginning; deleted a former (d); and recodified former (e) as (d).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (a); recodified former (b) through (d) as (a) through (c); in (b), substituted "Quarterly" for "Annual and quarterly".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Rewrote (a).

11:21-7.13 Paying benefits

(a) Except as stated in (b) below for prosthetic and orthotic appliances, in paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for services, using either the allowed charges or actual charges. Allowed charge 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, incorporated herein by reference published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

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

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier's contract rate should be paid.

Recodified from 11:21-7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), amended the address at the end of the introductory paragraph.
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Rewrote the introductory paragraph of (a); in (a)1, substituted "allowed" for "allowable"; and added (b).
Amended by R.2009 d.396, effective December 21, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 4817(a).
In the introductory paragraph of (a), deleted "medical" preceding the second occurrence of "services", and deleted ", and, for hospital services, based on actual charges" following "actual charges".

11:21-7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after January 1, 2014, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age and geography in accordance with the following restrictions:

1. Rates shall vary by age for each covered person age 21 or older. There shall be a per child rate for children under age 21 with a limit applied to the number of children rate equal to three times the child rate.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the counties listed below. A carrier shall determine which territory applies to a small employer on the basis of the address of the small employer's principal place of business. The six territories are the following:

i. Territory A consists of Essex, Hudson, and Union counties;

ii. Territory B consists of Bergen and Passaic counties;

iii. Territory C consists of Monmouth, Morris, Sussex, and Warren counties;

iv. Territory D consists of Hunterdon, Middlesex, and Somerset counties;

v. Territory E consists of Burlington, Camden, and Mercer counties; and

vi. Territory F consists of Atlantic, Cape May, Ocean, Salem, Cumberland, and Gloucester counties.

New Rule, R.1994 d.418, effective July 15, 1994 (operative September 11, 1994).
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).

Recodified from 11:21-7.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.13.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), inserted "or HMO-POS, " following "or HMO" in the introductory paragraph.
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Rewrote (a); and deleted (b).

11:21-7.15 Employer waiting period

A small employer carrier shall not be required to modify the waiting period provision of a health benefits plan except as of an anniversary date of the plan, and upon the request of a small employer.

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

11:21-7.16 Obligation to offer individual health benefits plans

Members that offer small employer health benefits plan in this State shall offer and make a good faith effort to market individual health benefits plans pursuant to N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-24.6. Such requirement may be satisfied by the member or the member's affiliate since the definition of "carrier" at N.J.S.A. 17B:27A-2 says carriers that are affiliated companies shall be treated as one company.

New Rule, R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Deleted designation (a); inserted a period following "seq"; and deleted (b).

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

11:21-7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of N.J.S.A. 17B:27A-19.3 and 25.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted a reference to N.J.S.A. 17B:27A-19.3 and 25 for a reference to the Act.

11:21-7A.2 Definitions

The following terms, when used in this subchapter, shall have the following meanings:

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21-11.2.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21-11.2.

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

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

"Small employer purchasing alliance," "purchasing alliance" or "alliance" means a small employer purchasing alliance as established pursuant to N.J.S.A. 17B:27A-25.3.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard benefits plan" and "Open nonstandard health benefits plan"; and deleted "Total employee months exposed".
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added "Small employer purchasing alliance".

11:21-7A.3 Filing of loss ratio reports

(a) Each carrier having standard health benefits plan policy forms, open or closed nonstandard health benefits plan policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference. The annual loss ratio report, beginning with 1997 data reported in 1998, shall:

1. Aggregate standard health benefit plans, other than alliance plans, including all standard and nonstandard riders and endorsements thereto;

2. Aggregate open nonstandard health benefits plans, including all riders and endorsements thereto;

3. Aggregate closed nonstandard health benefits plans including all riders and endorsements thereto; and

4. Aggregate alliance health benefits plans, including all riders and endorsements thereto.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year.

(c) Loss ratio reports submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a); and in (b), deleted exception at the end of the sentence.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), inserted "other than alliance plans" preceding "including", "and endorsements" preceding "thereto" in 1 and added 4.
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
In the introductory paragraph of (a), deleted "the five" preceding "standard".

11:21-7A.4 Contents of the loss ratio report

(a) A loss ratio report filed pursuant to N.J.A.C. 11:21-7A.3 shall include the following information:

1. The reporting carrier's name and address;

2. The carrier's earned premiums, before dividends or credits applicable to prior years, and claims for the preceding calendar year, calculated pursuant to the instructions of Exhibit GG;

3. The carrier's loss ratio determined by dividing the claims by the premiums;

4. The carrier's calculation of the dividends and credits to be issued pursuant to N.J.S.A. 17B:27A-25g(2). (A credit is a dividend paid in the form of a reduction in a current premium due, as distinguished from dividends paid in cash.);

5. An explanation of the carrier's plan to issue dividends and credits;

6. An explanation of the carrier's plan to distribute a dividend in the event of cancellation or termination by a policyholder;

7. Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-25g(2), N.J.A.C. 11:21-7A and instructions; and

8. Such other information as the Department may request.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (a)2, substituted a reference to dividends for a reference to refunds. and added ", calculated pursuant to the instructions of Exhibit GG" at the end.

11:21-7A.5 Dividend or credit plan

(a) If the preceding calendar year loss ratio for any of the classifications listed in N.J.A.C. 11:21-7A.3(a) is less than 80 percent, the carrier shall include within the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that classification in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 80 percent of the premiums for that classification in the preceding calendar year.

1. Carriers that issue health benefits plans through out-of-State trusts, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

2. Carriers that issue health benefits plans to small employers that are members of purchasing alliances shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

(b) The experience for all non-alliance standard health benefits plans shall be combined for dividend purposes.

(c) The experience for all alliance health benefits plans shall be combined for dividend purposes. The experience for

alliance health benefits plans shall not be combined with the experience for non-alliance standard health benefits plans, or the experience of open or closed non-standard health benefits plans, for dividend purposes.

(d) The experience for all open nonstandard health benefits plans shall be combined for dividend purposes. Open nonstandard health benefits plans shall not be combined with any standard health benefits plans or closed nonstandard health benefits plans.

(e) The experience for all closed nonstandard health benefits plans shall be combined for dividend purposes. Closed nonstandard health benefits plans shall not be combined with any standard health benefits plans or open nonstandard health benefits plan.

(f) The dividends or credits shall be issued to each small employer who was covered for any period in the preceding calendar year.

(g) The dividend or credit amount per policyholder shall be determined by multiplying the premium for each policyholder by the percentage calculated by dividing the total dividend or credit by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

(h) All dividends and credits shall be distributed by December 31 of the reporting year.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a) through (c); inserted a new (d); recodified former (d) through (f) as (e) through (g); in (e), substituted a reference to small employers for a reference to policyholders; in (f), substituted a reference to dividends and credits for a reference to refunds; and rewrote (g).
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), added 2; inserted a new (c) and recodified former (c) through (g) as (d) through (h).
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
In the introductory paragraph of (a), substituted "80" for "75" twice.

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

11:21-8.1 Purpose and scope

(a) The purpose of this subchapter is to establish which carriers are not members of the SEH Program and how those carriers may be certified as non-members.

(b) This subchapter applies to any carrier which files Annual Statements with the Department evidencing premium earned on group health insurance.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

11:21-8.2 Definitions

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Group health benefits plan" and "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21-8.3 Non-member status

(a) A carrier shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification unless the non-member certification is disapproved in writing by the Board. A carrier shall use the "Carrier Request for Non-Member Certification in the New Jersey Small Employer Health Benefits Program" form provided as Exhibit KK of these rules.

(b) A request for non-member certification shall state that:

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;

2. Other reasons which under law permit a carrier or entity to be certified a non-member.

Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted "shall" for "may" following "carrier" in the second sentence.

11:21-8.4 Non-member certification requests

(a) To be considered a non-member in any calendar year, a carrier or entity shall file with the Board a completed request for non-member certification no later than March 1 of the following calendar year. Such request shall be sent to the SEH Program Administrator or Executive Director as specified at N.J.A.C. 11:21-1.3.

(b) All requests for non-member certification shall contain the statements required in N.J.A.C. 11:21-8.3 and be certified by a duly authorized officer of the carrier.

(c) A copy of such request also shall be filed by the carrier or other entity with the Commissioner as follows:

Attn: SEH Annual Certification of Non-Member Status
Life/Health Actuarial Services
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21-8.3.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director in the second sentence.

11:21-8.5 Decisions on filings by the Board

The Board shall, if it determines that a carrier's non-member certification is incomplete, incorrect, or not in substantial compliance with this subchapter or other law, deny a request for non-member certification in writing, stating the reasons for the determination, after review of a carrier's filing. A copy of such decision shall be sent to the carrier and to the Commissioner.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.

11:21-8.6 Review

A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board pursuant to procedures set forth in N.J.A.C. 11:21-2.17.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (c), substituted a reference to 45 days for a reference to 30 days in the first sentence.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

SUBCHAPTER 9. INFORMATIONAL RATE FILING REQUIREMENTS PURSUANT TO THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

11:21-9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to N.J.S.A. 17B:27A-17 et seq.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to N.J.S.A. 17B:27A-17 et seq.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted references to N.J.S.A. 17B:27A-17 et seq. for references to the Act throughout.

11:21-9.2 Definitions

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

"Classification factor" means a factor used to vary rates based upon characteristics of the employee, employer or policyholder.

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21-11.2.

"Effective date" means the date on which coverage begins for the policyholder.

"Health benefits plan" means any standard health benefits plan or nonstandard health benefits plan including any rider or endorsement thereto.

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

"Nonstandard rider" means a rider or endorsement developed by a carrier to be offered with one or more of the standard health benefits plans.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21-11.2.

"Plan" means a policy or contract form under which policies, contracts or certificates are issued evidencing benefits for expenses incurred or coverage of services rendered when referring to a type of health benefits plan.

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

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

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard health benefits plan" and "Open nonstandard health benefits plan"; and rewrote "Nonstandard health benefits plans".
Amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Added "Effective date".

11:21-9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993

(a) All carriers issuing policies, contracts or certificates under health benefit plans to small employers, including any standard or nonstandard rider option, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A plan schedule for each of the standard health benefits plans and nonstandard health benefits plans offered, outlining:

i. The benefit options available;

ii. The delivery system(s) for each plan;

iii. The in-network and out-of-network coinsurance percentages and/or copays for selective contracting arrangements or HMO point-of-service arrangements;

iv. The benefit differential for each nonstandard rider offered, separately specifying benefit increases and benefit decreases;

v. The basic premium rate or rating factors applicable for each option including the difference when Medicare is primary or secondary, based on actual employee or spouse Medicare coverage status. Reduced premium rates or rating factors must be provided when Medicare is primary for an employee eligible for Medicare by reason of age; and

vi. The coverage period, if any, for which the rates for a group are guaranteed;

2. A rate manual containing:

i. The numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of the covered persons in accordance with N.J.A.C. 11:21-7.14;

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 set forth pursuant to (a)1v above into the rates charged to a small employer group;

iii. A detailed example calculation, in the proposal format used by the carrier, for any one plan including a rider or POS option, showing all of the steps to develop premiums for a small group and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State; and

iv. A specification of the rule, which must be invariable, stating if the issue rate is based on the issue enrollment or the proposal rate.

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rate, which shall include:

i. Recent claim cost experience, a description of the source of the claim costs and the time period for which the claim costs were calculated;

ii. The claim, administrative expense and profit assumptions used in developing the anticipated loss experience and the basic premium rates specified in (a)1v above, and the anticipated distribution of business by rating classification described in (a)2 above;

iii. The assumptions underlying the reduced premium rates or rating factors where Medicare is primary for the employee or spouse based on the actual Medicare coverage status of the employee or spouse;

iv. A statement whether or not the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 3iv(4), 3iv(5) or 3iv(6) below, as appropriate;

v. A summary of the overall change in rate levels, including:

(1) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates that were in effect one year prior to the effective date of the rate filing; and

(2) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates contained in the immediately prior rate filing;

vi. A certification signed by a member of the American Academy of Actuaries attesting as follows:

(1) The filing is accurate and complete and complies with the provisions of this subchapter;

(2) The issue period for which the filed rates are applicable, which period shall not exceed 12 months;

(3) The anticipated incurred loss ratio for each plan, which shall not be less than 80 percent of the premium therefore;

(4) For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996, that the rating methodology will not provide rates (for an individual and for each family status) for the highest rated group in this State which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group in this State for each plan and option;

(5) That rates to be charged to any group do not vary based on any classification factor other than those permitted in (a)2i above; and

(6) Whether the rates for the Open Nonstandard and Closed Nonstandard plans are on the same or a different basis as the rates for the Standard plans and, if different, the average percentage relationship to the Standard plan basis; and

vii. A certification that the actuarial memorandum contains confidential and proprietary information, if it is the actuary's belief that it does.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan (including any standard or nonstandard rider option after September 11, 1994), an open nonstandard health benefits plan or a closed nonstandard health benefits plan, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above.

1. Carriers that issued or renewed open nonstandard health benefits plans or closed nonstandard health benefits plans prior to the effective date of this amendment shall have until 90 days following the effective date of this amendment within which to come into compliance with this subchapter.

(c) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above.

(d) In addition to meeting the requirements of (a) through (c) above, an informational rate filing shall not be considered complete unless the plan schedule and rate manual meet the following format requirements:

1. Each page shall contain the name of the carrier for which the filing is made;

2. Each page shall be distinctively numbered;

3. If future filings may be made by way of replacement pages only, then each page shall be dated clearly and distinctively; and

4. In all instances, there shall be a table of contents which shall include the date of the most recent filing, and shall include the date(s) of the respective pages when filings are made by way of replacement page.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the section.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a)3iv(5), substituted "(a)2i" for "(a)2ii".
Amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Rewrote the section.
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
In (a)3ii, inserted "claim, administrative expense and profit"; and in (a)3vi(3), substituted "80" for "75" and "therefore" for "therefor".

11:21-9.4 Purchasing alliances

(a) All carriers providing discounts to small employer purchasing alliances shall file an informational rate filing with the Commissioner prior to the date of providing such discounts, which shall include the following data:

1. A statement that the discount is based on reductions in anticipated expenses and profit margins and not on favorable claims experience;

2. Information regarding the discounts, including:

i. The small employer rate filings ("reference filing") pursuant to N.J.A.C. 11:21-9.3 to which the discounts apply;

ii. Eligibility requirements that a small employer group must satisfy, including participation requirements or cost-sharing requirements;

iii. The amount of the discounts expressed as a percentage of the non-alliance premium for the same coverage and small employer group. If the same discount is not offered to all purchasing alliances, the criteria for the variation in the discount, which shall not include any of the factors set forth at N.J.A.C. 11:21-21.4(a);

iv. The contract issue or renewal period to which the discounts apply, the time period for which the discount is guaranteed, and any conditions for maintaining the discount; and

v. A statement that the same discount is available to all members of the purchasing alliance;

3. Information regarding the application of the discount to a particular group, including:

i. A written description in plain language of the method by which the discounted rate is obtained from the reference rate; and

ii. A detailed example calculation, in the proposal format used by the carrier, of the application of the discount to the example calculation found in the reference filing, showing all the steps necessary to develop the discounted premium from the undiscounted premium, and demonstrating the adjustment, if any, to

achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State;

4. An actuarial memorandum setting forth the assumptions used in the development of the discount, which shall include:

i. The anticipated claim cost for the purchasing alliances;

ii. A demonstration that the discount is based on the anticipated expenses (including marketing and claims administration expenses) and profit margins, identifying those differences from the anticipated expenses and profit margins in the reference filing that are the only bases for the purchasing alliance discount;

iii. A statement whether or not the policyholder shall or may receive policyholder dividends, other than the dividends required by N.J.S.A. 17B:27A-25(g)(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 4iv(4), 4iv(5) or 4iv(6) below, as appropriate; and

iv. A certification signed by a member of the American Academy of Actuaries attesting to the following:

(1) That the filing is accurate and complete, and complies with the provisions of this subchapter;

(2) The issue period for which the discount is applicable;

(3) The anticipated incurred loss ratio for each plan offered to purchasing alliances, which shall not be less than 80 percent of the premium;

(4) That the rating methodology, taking into account both discounted and undiscounted rates, shall not provide rates for the highest group in the State that are greater than 200 percent of the rates (for an individual and each family status) produced for the lowest rated group in this State for each plan and option;

(5) That the rates to be charged to any group do not vary based on a classification factor other than those permitted in N.J.A.C. 11:21-9.3(a) 2i;

(6) That discounted rates do not result in rates that vary between groups based upon a health status-related factor; and

(7) That the anticipated incurred loss ratio in (a)4iv(3) above exceeds the anticipated incurred loss ratio for the reference filing by an amount that reflects the expense and profit savings attributed to the purchasing alliance.

(b) A single filing shall be made, even if multiple purchasing alliances are covered. The addition of purchasing alliances or other changes shall require submission of an amendment or modification to the rate filing within 30 days of such change.

New Rule, R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Former N.J.A.C. 11:21-9.4, Informational filing procedures, recodified to N.J.A.C. 11:21-9.5.
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
In (a)4iv(3), substituted "80" for "75".

11:21-9.5 Informational filing procedures

(a) Informational filings submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Informational Rate Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 60 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21-9.3. If the Commissioner takes no action with respect to the informational filing within 60 days of the date of submission thereof, the information filing shall be deemed complete.

(c) If the informational filing is incomplete but in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the carrier shall, within 30 days of receipt of written notice in (b) above, provide the Commissioner with the information required to complete the filing. Failure on the part of the carrier to comply with the provisions of this subsection may result in the imposition of a penalty pursuant to N.J.A.C. 11:21-9.6.

(d) If the informational filing is incomplete and not in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the Commissioner shall provide written notice to the carrier specifying the portions of the filing which are deficient and the information required to be submitted by the carrier. Upon receipt of notice from the Commissioner that the filing for any health benefits plan is not in substantial compliance, no contract, policy or certificate shall be entered into or renewed using the submitted rates until the Commissioner has determined that the informational filing is

in substantial compliance or complete, and has provided written notice of that fact to the carrier. If the Commissioner takes no action within 30 days of the carrier's submission of information in an effort to render the filing in substantial compliance, the filing shall be deemed to be in substantial compliance.

(e) Any carrier aggrieved by a determination of the Commissioner pursuant to (b), (c) or (d) above may request a hearing on the Commissioner's determination, within 20 days of the receipt of notice of such determination, as follows:

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

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

ii. A copy of the notice involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

2. The hearing shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

(f) The Commissioner may disapprove a purchasing alliance rate reduction if it results in rates that are excessive, inadequate or unfairly discriminatory.

1. Rates will be considered excessive if they are projected to give rise to a loss ratio that is less than the loss ratio for the reference rate filing, increased by an amount that reflects the savings giving rise to the discount.

2. Rates will be considered inadequate if they result in a subsidization of the alliance business by the non-alliance business.

3. Rates will be considered unfairly discriminatory if they are based on a health status-related factor of the group or any individual eligible for coverage in the group.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (b), increased periods for providing written notice and taking action from 30 to 60 days.
Recodified from N.J.A.C. 11:21-9.4 and amended by R.2002 d. 342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added (f). Former N.J.A.C. 11:21-9.5, Public disclosure of filed information, recodified to N.J.A.C. 11:21-9.6.

11:21-9.6 Errors in rate quotations and rate calculation

(a) Any carrier that quotes, bills or collects a premium to or from a small employer that is less than the rate shown in the carrier's informational SEH rate filing in effect at the time the premium is billed or collected shall:

1. Provide written notice to the small employer of the error as soon as possible but no later than 30 days after discovery of the error;

2. Be prohibited from charging, collecting, offsetting or otherwise recouping the amount of the undercharges; and

3. Continue to charge the erroneous rate for a period of at least 60 days from the date the written notice of the error is received by the small employer.

(b) Any carrier that quotes, bills or collects a premium to or from a small employer that is more than the rate shown in the carrier's informational SEH rate filing in effect at the time the premium is billed or collected shall:

1. Immediately cease charging the incorrect rate and charge the correct rate;

2. Provide written notice to the small employer of the error as soon as possible but no later than 30 days after discovery of the error; and

3. Send the small employer a refund or post a premium credit within 30 days after discovery of the error for the full amount of all overcharges.

(c) If more than 50 small employer groups were undercharged or overcharged as a result of the error, a carrier shall provide the Department at the address listed at N.J.A.C. 11:21-9.4(a) with a certification describing the nature and scope of the error, including a list of all small employers affected and a sample copy of the notice to all small employers.

(d) The requirements of this section shall not apply to any deviation in rates from the filed rates that is less than one-quarter of one percent (.25 percent) or that arises from a rounding error of less than $1.00.

New Rule, R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21-9.6, Public disclosure of filed information, recodified to N.J.A.C. 11:21-9.7.

11:21-9.7 Public disclosure of filed information

(a) All data or information filed with the Department pursuant to N.J.A.C. 11:21-9.3(a) are public records and may be disclosed in accordance with N.J.S.A. 47:1A-1 et seq., except that actuarial memoranda which contain confidential and proprietary information pursuant to N.J.A.C. 11:21-9.3(a) 3 shall not be disclosed by the Department to any person other than employees and representatives of the Department.

(b) A carrier shall separately identify in all informational rate filings the confidential actuarial information from all other information required by this regulation. If not so identified, all information shall be considered public information and subject to disclosure.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Recodified from N.J.A.C. 11:21-9.5 by R.2002 d. 342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Former N.J.A.C. 11:21-9.6, Penalties, recodified to N.J.A.C. 11:21-9.7.
Recodified from N.J.A.C. 11:21-9.6 by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21-9.7, Penalties, recodified to N.J.A.C. 11:21-9.8.

11:21-9.8 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by N.J.S.A. 17B:27A-43.

Recodified from N.J.A.C. 11:21-9.6 by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Recodified from N.J.A.C. 11:21-9.7 and amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Substituted "N.J.S.A. 17B:27A-43" for "law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey".

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21-10.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

(b) This subchapter shall apply to all carriers that are, or become, members of the SEH Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member on the report filing due date.

11:21-10.2 Definitions

Words and terms used in this subchapter shall have the meanings as set forth in the Act or the chapter, unless the context clearly indicates otherwise.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21-10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before March 1. Every member shall complete Parts A, B, C and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as (a)2 below implies. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program Administrator or Executive Director, as set forth at N.J.A.C. 11:21-2.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted "April 15, 1994 and annually thereafter no later than" following "before" in the first sentence of the introductory paragraph; and in (b), inserted a reference to the Executive Director.

11:21-10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers, less any refunds paid by the carrier during that calendar year as a result of the application of the minimum loss ratio requirement.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual NAIC statement blank, adjusted to meet the definition of group health benefits plan and exclude refunds as described in (a)1 above, as necessary.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (a)2.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

11:21-10.5 Certification

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

11:21-10.6 Failure to comply

Failure to comply with the reporting provisions of this subchapter shall result in the Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium based

upon which that member's market share allocation of assessments shall be calculated by the Board.

SUBCHAPTERS 11 THROUGH 14.(RESERVED)

SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

11:21-15.1 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-38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A-26.

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

11:21-15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1, 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-17 et seq.

"Financially impaired" means a member which, after November 5, 1993, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations pursuant to N.J.S.A. 17B:27A-38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A-26, as applicable.

11:21-15.3 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-38 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. 11:21-15.4, 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. 11:21-15.4. 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. 11:21-15.4 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:

SEH Program
Request for Relief
New Jersey Department of Banking and Insurance
Division of Financial Solvency
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (f), updated address.

11:21-15.4 Informational filing requirements

(a) When requesting relief from obligations pursuant to N.J.S.A. 17B:27A-26b or 17B:27A-38, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:

i. The name of the applicant;

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

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

iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

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

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

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

5. If the applicant is a member of a holding company system, the following shall be provided:

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

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

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

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant.

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

7. A report signed by the attesting actuary referred in (a)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

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

10. 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 health benefits plans issued pursuant to N.J.S.A. 17B:27A–17 et seq. The projections shall assume the same rate of assessment as in the first year for the subsequent years, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

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

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

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

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

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

12. A non-refundable filing fee of $1,000, unless the applicant is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32–31 et seq. or such similar law of the applicant's state of domicile; and

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

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

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I _____ certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:21–15 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the applicant."

11:21–15.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A–1 et seq., except for the following items, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

1. N.J.A.C. 11:21–15.4(a)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:21–15.4(a)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:21–15.4(a)3—most recent financial examination report;

4. N.J.A.C. 11:21–15.4(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. 11:21–15.4(a)8—annual statement filed immediately preceding date of filing;

6. N.J.A.C. 11:21–15.4(a)12—non-refundable filing fee; and

7. N.J.A.C. 11:21–15.4(a)13—additional information required by the Commissioner to evaluate a particular filing.

11:21–15.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A–26b or 17B:27A–38 as applicable, that the member is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A.

17B:27A–38, the member shall remain liable to the SEH Program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the SEH Program if it fails to pay assessments.

(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 of the amount deferred is paid to the Board.

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

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

11:21–15.7 Hearings

(a) If the Commissioner denies a member's request for relief made pursuant to this subchapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

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

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the member believes that the Commissioner's findings of fact are erroneous.

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

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

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

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

11:21–15.8 Notice of the SEH Program

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

11:21–15.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member HMO asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it reasonably anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, pursuant to N.J.S.A. 17B:27A–26a, 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 anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member; and

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–26a.

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

(c) Any member HMO denying coverage pursuant to (a) above shall not offer coverage in the small employer market within such service area for a period of at least 180 days after the date that the carrier first denies coverage.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Added (c).

11:21–15.10 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, medical service corporations, hospital service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation, medical service corporation, hospital service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32–31 et seq.

11:21–15.11 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 pursuant to N.J.S.A. 17B:27A–43 and the SEH Program Plan of Operation as codified at N.J.A.C. 11:21–2, 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.

Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Amended N.J.S.A. and N.J.A.C. references.

SUBCHAPTER 16. WITHDRAWALS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET AND WITHDRAWALS OF PLAN(S), PLAN OPTION(S) AND COPAYMENT/ DEDUCTIBLE OPTION(S)

11:21–16.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the small employer market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing and nonrenew: a specific standard plan issued using a particular delivery option; a plan option; a specific standard benefit rider; or a specific copayment/deductible option available under the standard plans. The subchapter applies to all small employer carriers issuing or renewing policies or contracts after November 30, 1992. Pursuant to the provisions of N.J.S.A. 17B:27A–17 et seq., every policy or contract issued to a small employer in this State shall be renewable with respect to all eligible employees or dependents at the option of the policy or contractholder or small employer, except under the circumstances prescribed by N.J.S.A. 17B:27A–23a, c, d, e, f, h, and i. One of the circumstances delineated therein is where a carrier ceases to do business in the small employer health benefits plans market in New Jersey pursuant to N.J.S.A. 17B:27A–23e.

(b) This subchapter applies to all small employer carriers as defined in this subchapter that seek to cease doing business in the small employer market.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), changed N.J.S.A. reference.
Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
In (a), added the second sentence and substituted "or" for "of" following "renewing policies" in the third sentence.

11:21–16.2 Definitions

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

"Affiliate" or "affiliated company" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the carrier that initiates a withdrawal.

"Cease doing business" for purposes of these rules means withdraw or withdrawal.

"Market withdrawal" means the nonrenewal on the anniversary date of all inforce nonstandard health benefits plans or small employer health benefits plans, or both as appropriate, issued to small employers without offering replacement with a small employer health benefits plan (or a nonstandard health benefits plan, if offered through an association, multiple employer arrangement or out-of-State trust that continues to market its nonstandard health benefits plans pursuant to N.J.S.A. 17B:27A-17 et seq.), except where such action is taken pursuant to N.J.S.A. 17B:27A-23a, c, d, f, h and i or is approved by the Commissioner in accordance with N.J.A.C. 11:21-11.

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

"Plan option withdrawal" means a carrier's cessation of the issuance of a standard health benefits plan option and the nonrenewal on the anniversary date of all inforce standard small employer health benefits plans issued with that option.

"Plan withdrawal" means a carrier's cessation of the issuance of a standard health benefits plan and the nonrenewal on the anniversary date of all inforce small employer health benefits plans of that plan type.

"State" means the State of New Jersey.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In the introductory paragraph, changed N.J.A.C. reference; and in "Withdraw" or "withdrawal", substituted "nonrenewal" for "cancellation on a date certain or the termination" following "means the", and changed N.J.S.A. reference.
Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Added "Market withdrawal", "Plan option withdrawal", and "Plan withdrawal"; deleted "'Withdraw' or 'withdrawal'".

11:21-16.3 General provisions for market withdrawal

(a) No small employer carrier shall nonrenew except in accordance with N.J.S.A. 17B:27A-23a, c, d, f, h and i or refuse to issue any small employer health benefits plan unless the small employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

(b) Any small employer carrier which seeks to withdraw from the small employer market in the State shall provide the Commissioner with written notification of its intent to withdraw not later than eight months prior to the nonrenewal on the anniversary date of each in force policy or contract.

1. Until such time as the withdrawal shall be completed, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A-17 et seq. and all rules promulgated thereunder.

2. A withdrawing carrier shall cease issuing new policies no more than two months after filing a notice of intent to withdraw with the Commissioner.

(c) The notice of withdrawal to the Commissioner shall be sent to the attention of: SEH Withdrawal Notice, Life and Health Division, New Jersey Department of Banking and Insurance, PO Box 325, Trenton, NJ 08625-0325, and shall include an original and two copies of the following information:

1. The carrier's percentage market share in the small employer market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

2. A statement, describing with specificity, the reasons for which the carrier is withdrawing from the small employer market in this State;

3. A statement indicating whether the carrier has any affiliates writing any health lines in this State, the names of such affiliates and the lines of insurance written and a statement indicating whether any such affiliates will continue to write small employer health benefits plans;

4. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing;

5. A statement specifying the date or dates upon which the small employer health benefits plans and nonstandard health benefits plans, as applicable, shall be nonrenewed specifying the date upon which all in force policies or contracts shall begin to be nonrenewed, which shall be the anniversary dates of the policies or contracts of each policyholder;

6. The date upon which the carrier shall cease writing any new nonstandard health benefits plans (if through an association, multiple employer arrangement or out-of-State trust) or small employer health benefits plans, as applicable, which shall be no later than two months after the date the carrier has filed its notice with the Commissioner; and

7. A copy of the form of notice required pursuant to (f) below, which is to be mailed to each affected small employer.

(d) The Commissioner shall review the notice of withdrawal to determine whether it complies with (c) above and whether sufficient notice will be provided to policyholders. The Commissioner shall notify, in writing, the small employer carrier of any deficiencies and the requirements which are necessary to bring it into compliance with N.J.S.A. 17B:27A-23 and this subchapter.

(e) Any small employer carrier which seeks to withdraw from the small employer market shall, not later than two months following the date of notification to the Commissioner, nor less than six months in advance of the nonrenewal on the anniversary date of the policy or contract, mail notices to every small employer insured by the carrier, with copies for each covered person, informing the small employer and all covered persons that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each small employer shall be sent by certified mail and shall include the following information:

1. The date upon which the policy or contract shall be nonrenewed;

2. That the policy or contract is being nonrenewed under the authority of N.J.S.A. 17B:27A-23e and this subchapter;

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

4. A statement that the small employer may contact its broker for additional information regarding the withdrawal;

5. A notice that a list of active small employer carriers and information about small employer health benefits coverage may be obtained by writing to the New Jersey Small Employer Health Benefits Coverage Program Board, PO Box 325, Trenton, NJ 08625-0325 or by calling 1-800-263-5912 or accessing the Board's website at http://www.state.nj.us/dobi/reform.htm, and requesting a copy of the "Get the Facts" brochure; and

6. A statement that pursuant to N.J.S.A. 17B:27A-19, all carriers offering small employer health benefits plans must issue coverage to any small employer group which requests coverage under a small employer health benefits plan, meets the participation requirements of the carrier, and pays the required premium for the coverage.

(f) A withdrawing small employer carrier shall provide at least one copy of its notice of intent to cancel on a date certain or termination on the anniversary of each policy or contract, to the producer of record for each policy or contract. The notice shall be sent by certified mail, no less than six months prior to the effective date of withdrawal.

(g) Simultaneous with its notice to the Commissioner, a withdrawing small employer carrier shall submit a notice to the Board at the address specified at N.J.A.C. 11:21-1.2, which:

1. Indicates that the carrier shall withdraw from the State of New Jersey;

2. States that the carrier will nonrenew its in force policies or contracts on their anniversary date; and

3. Sets forth the date when the nonrenewals shall begin.

(h) Following the initial notice to the small employer, a small employer carrier shall submit subsequent notices to the small employer of the nonrenewal on the anniversary date of the contract and the date upon which the nonrenewal shall occur. Such notice shall be included with each monthly premium bill or premium notice issued prior to the date of nonrenewal. Where no monthly premium statement is transmitted, a small employer carrier shall provide a small employer with no fewer than three notices, which notices shall be sent at a minimum on the sixth, third and last month prior to the date of nonrenewal.

(i) Any small employer carrier that files a notice of withdrawal from the small employer market with the Commissioner shall simultaneously file a notice of withdrawal from the individual health coverage market pursuant to N.J.S.A. 17B:27A-6c(4) and N.J.A.C. 11:20-18.5.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Rewrote the section.
Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
In (e)5, inserted "or accessing the Board's website at http://www.state.nj.us/dobi/reform.htm"; and added (i).

11:21-16.4 Restrictions on writings following a market withdrawal

Any small employer carrier that ceases to do business pursuant to this subchapter shall be prohibited from writing new business in the New Jersey small employer market for a period of five years from the date of termination of the last health benefits plan nonrenewed under this subchapter and shall be prohibited from writing new business in the New Jersey individual health coverage market for a period of five years from the date of termination of the last individual health coverage plan nonrenewed.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Rewrote the section.
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
Inserted "and shall be prohibited from writing new business in the New Jersey individual health coverage market for a period of five years from the date of termination of the last individual health coverage plan nonrenewed".

11:21-16.5 General provisions for withdrawal of plan, plan option and copayment/deductible option

(a) No carrier shall cease to issue or nonrenew a standard small employer health benefits plan, plan option or copayment/deductible option required or permitted to be offered pursuant to N.J.A.C. 11:21-3 until the carrier submits a notice of intent to withdraw a plan, plan option or copayment/deductible option with the Commissioner in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew a standard small employer health benefits plan pursuant to this section only if:

1. The copayment/deductible option is not required to be offered pursuant to N.J.A.C. 11:21-3.1(b) or (c); or

2. In the case of a copayment/deductible option required to be offered pursuant to N.J.A.C. 11:21-3.1, the carrier meets its obligation to offer the standard small employer plans and required copayment/deductible options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey small employer groups.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to calculate the family deductible based on a two times individual or three times aggregate basis, and an HMO's option to offer prescription drug coverage with either a $15.00 copayment or with 50 percent coinsurance.

(d) A carrier that seeks to withdraw a plan, plan option or copayment/deductible option pursuant to this section shall provide the Commissioner with written notification of its intent to withdraw a plan, plan option or copayment/deductible option. An original and two copies of the notice of intent to withdraw a plan, plan option or copayment/deductible option shall be sent to the attention of: SEH Withdrawal Notice, Life and Health Division, New Jersey Department of Banking and Insurance, PO Box 325, Trenton, New Jersey 08625-0325, and shall include the following information:

1. The name of the carrier;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan, plan option or copayment/deductible option withdrawal;

3. A specific description of the reasons the carrier is withdrawing the plan, plan option or copayment/deductible option;

4. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contract holders shall include the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option or copayment/deductible option;

ii. The date upon which the plan, plan option or copayment/ deductible option shall be nonrenewed;

iii. A statement that the plan, plan option or copayment/deductible option is being nonrenewed under the authority of this subchapter;

iv. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option or copayment/ deductible option withdrawal; and

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option or copayment/deductible option withdrawal; and

5. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the same information as the notices to policy and contract holders.

(e) The Commissioner shall review the notice of intent to withdraw a plan, plan option or copayment/deductible option to determine whether it complies with the filing requirements of (d) above. The Commissioner shall notify the carrier, in writing, of any deficiencies and the requirements that are necessary to bring it into compliance with this section.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option or copayment/deductible option shall:

1. Not more than 60 days after the date of the notice of intent to withdraw the plan, plan option or copayment/deductible option, cease issuing the standard small employer health benefits plan, plan option or copayment/deductible option;

2. Not more than 60 days following the date of notice of intent to withdraw the plan, plan option or copayment/deductible option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice, in the same format submitted to the Commissioner pursuant to (d)4 above, to every policy or contract holder, informing the policy or contract holder that the plan, plan option or copayment/deductible option will be nonrenewed on the plan's anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be

included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium is transmitted, send a notice at least 30 days prior to nonrenewal; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice in the same format submitted to the Commissioner pursuant to (d)5 above, to the producer of record, if any, for each policy or contract.

New Rule, R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.5, Penalties, recodified to N.J.A.C. 11:21-16.6.

11:21-16.6 Penalties

Failure to comply with the requirements of this subchapter shall result in the imposition of penalties pursuant to N.J.S.A. 17B:27A-43 and any and all other penalties provided by law.

Recodified from N.J.A.C. 11:21-16.5 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.6, Other policyholder rights unaffected, recodified to N.J.A.C. 11:21-16.7.

11:21-16.7 Other policyholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract issued by a small employer carrier.

Recodified from N.J.A.C. 11:21-16.6 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.7, Revocation of a notice of intent to withdraw, recodified to N.J.A.C. 11:21-16.8.

11:21-16.8 Revocation of a notice of intent to withdraw

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

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

New Rule, R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), changed N.J.A.C. reference in the introductory paragraph, substituted "nonrenewed" for "cancelled, or terminated" in 1, and deleted former 2 through 4.
Recodified from N.J.A.C. 11:21-16.7 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21-17.1 Plan identification and marketing materials

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

(b) All eligibility, coverage and exclusions described in the small employer carrier's marketing and/or promotional material shall be consistent with the Act and this chapter.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "standard" preceding "health benefits plan" throughout and inserted reference to HMO POS.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Deleted former (c).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), substituted " eligibility, coverage and exclusions described" for "terms, definitions, and text used".
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In (a), deleted "A," preceding "B,".

11:21-17.2 Retention of marketing and promotional materials

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

11:21-17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix, incorporated herein by reference, shall be

signed by a duly authorized officer of the small employer carrier. Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer carrier disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general.

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

Amended by R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "carrier" preceding "disseminates promotional or marketing"; and in (b), inserted March 1 deadline.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted ", or by February 15, 1994, whichever date is later" at the end.

11:21-17.4 Disclosure of premiums for riders

(a) A small employer carrier that offers standard health benefits plans as amended by one or more optional benefit riders shall list the premium or percentage change for the ridered plan separately from the premium or percentage change for the unridered standard health benefits plan on rate quotes prepared by the small employer carrier.

(b) A small employer carrier that files an optional benefit rider pursuant to N.J.A.C. 11:21-3.2 shall include, as part of the certification required by N.J.A.C. 11:21-3.2(a)6v(6), a statement that the premium or percentage change for ridered standard health benefits plans will be listed separately from the premium or percentage change for the unridered standard health benefits plan on rate quotes prepared by the carrier.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Substituted references to a "Get the Facts" brochure for references to a Buyer's Guide throughout.
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5071(a), 36 N.J.R. 1594(a).
Section was "Get the Facts" brochure.
New Rule, R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
In (b), updated the N.J.A.C. reference.

11:21-17.5 Producer contracts

(a) A small employer carrier may select those insurance producers, as defined by N.J.S.A. 17:22A-2j, with whom it chooses to contract. No small employer carrier shall terminate or refuse to renew the contract of its insurance producers because of health status-related factors of eligible employees or dependents, the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier, or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

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

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), and (b), substituted "health status-related factors of eligible employees or dependents, or the" for "the health status, claims experience,".
Amended by R.2000 d.67, effective January 26, 2000 (operative April 1, 2000).
See: 32 N.J.R. 168(a), 32 N.J.R. 708(b).
In (b), inserted "the number of eligible employees or the number of enrollees," following "or dependents,".
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), rewrote the second sentence; in (b), substituted "employees enrolled" for "enrollees" following "the number of".

SUBCHAPTER 18. PETITIONS FOR RULES

11:21-18.1 Scope

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

11:21-18.2 Procedure for petitioner

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

1. Name and address of the petitioner;

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

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

4. References to the statutory authority of the Board to take the requested action; and

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:21-1.3.

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

corrected and the petition may be resubmitted for further consideration.

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

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), added 5; added a new (b) and recodified former (b) and (c) as (c) and (d).

11:21-18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21-18.2 the Board shall, within 15 days, file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

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

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

4. The date the petition was received.

(b) Within 60 days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

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

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

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

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

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

1. Denying the petition;

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

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

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted ", within 15 days," following "shall" in the introductory paragraph.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), substituted "60" for "30" in the introductory paragraph.

SUBCHAPTERS 19 THROUGH 22.(RESERVED)

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

11:21-23.1 Purpose and scope

(a) The purpose of this subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings.

(b) This subchapter shall apply to all rulemaking of the Board.

11:21-23.2 Public notice regarding proposed rulemaking

(a) Unless the Board proposes a rule pursuant to the special procedures set forth at N.J.S.A. 17B:27A-51, the Board shall provide for the following four types of public notice for rule proposals in accord 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:

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 website at: http://www. njdobi.org;

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 website; and

4. 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 made available to the Board's list of "interested persons" by e-mail or hard copy. Interested persons are those who have informed the Board in writing that they wish to receive

notice of the Board's proposed regulations, as well as those people or entities that the Board determines are the subject of or significantly related to the rulemaking so that the persons most likely to be affected by or interested in the intended action receive notice.

11:21-23.3 Extension of the public comment period

(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 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 indicated a previously unrecognized impact on a regulated entity or persons; or

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

11:21-23.4 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 a 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.

11:21-23.5 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 of a notice at the office of the Secretary of State;

2. Posting of a notice at the office of the Board at the address set forth at N.J.A.C. 11:21-1.3;

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

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

5. Mailing, either by hard copy or electronically, of the notice to a distribution list of those persons who have requested in writing to be informed of the Board's meeting schedule.

11:21-23.6 Board mailing list of interested parties

(a) For the purpose of disseminating information about the SEH Program, including information about rulemaking and meeting dates, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of members shall be based upon the member carriers' addresses filed with its most recently filed Exhibit CC Market Share 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 above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

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

APPENDIX

EXHIBIT A

(RESERVED)

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
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).
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).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2013 d.038, effective January 24, 2013.
See: 45 N.J.R. 107(b), 45 N.J.R. 332(a).
Repealed by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Small Group Health Benefits Basic Policy".

EXHIBIT B

(RESERVED)

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan B]".

EXHIBIT C

(RESERVED)

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan C]".

EXHIBIT D

OVER-AGE DEPENDENT COVERAGE RIDER

[Policy]holder:
Group Policy No:
Effective Date:

This Rider amends the Group [Policy] and the [Certificates] issued to over-age dependents who elected coverage under the **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** provision.

I. The **DEPENDENT COVERAGE** section is deleted in its entirety and replaced with the following section entitled **OVER-AGE DEPENDENT COVERAGE.**

OVER-AGE DEPENDENT COVERAGE

Eligible Dependents

An Employee's child by blood or law who:
a) has reached the limiting age of 19 or 23, as applicable, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the over-Age Dependent continuation coverage begins.

Enrollment Requirement

To continue group health benefits, the Over-Age Dependent must make written election to [the Carrier].

For a Dependent whose coverage has not yet terminated due to the attainment of age 19 or 23, as applicable, the written election must be made within 30 days prior to termination of coverage due to the attainment of age 19 or 23.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:
a) If a person did not qualify because he or she was married or a partner in a domestic partnership or civil union, the notice must be given within 30 days of the date he or she is no longer married or the domestic partnership or civil union is dissolved.
b) If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date he or she no longer has a Dependent.
c) If a person did not qualify because he or she either was not a resident of New Jersey or was not a full-time student at an Accredited school, the election must be made within 30 days of the date he or she becomes a resident of New Jersey, or becomes a full-time student at an accredited school.
d) If a person did not qualify because he or she was covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

An Over-Age Dependent may make written election to continue coverage during a 30 day period beginning on each anniversary date of the date the dependent lost coverage due to attaining the limiting age, provided he or she meets the definition of an "Over-Age Dependent" during that 30-day period.

When Over-Age Dependent Coverage Starts
The effective date of the continued coverage will be the later of:
a) the date the Over-Age Dependent gives written notice to [the Carrier]; or
b) the date the Over-Age Dependent pays the first premium; or
c) the date the Dependent would otherwise lose coverage due to attainment of the limiting age.

When Over-Age Dependent Coverage Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31;
   2. marries or enters into a domestic partnership or a civil union partnership;
   3. acquires a Dependent;

4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare

b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except. if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

II. Coverage for an Over-Age Dependent is single coverage. Any Deductible, Coinsurance and/or Copayments paid by an Over-Age Dependent is independent of any Deductible, Coinsurance and/or Copayments paid by the Over-Age Dependents parents, or siblings. Any provision in the Group [Policy] [and] [,] [Certificate] [and optional benefit rider] allowing for a family deductible or a family Maximum Out of Pocket does not apply to the coverage for the Over-Age Dependent.

III. The following provisions are deleted in their entirety:
a) COBRA CONTINUATION RIGHTS,
b) NEW JERSEY GROUP CONTINUATION RIGHTS,
c) A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS,
d) AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE,
e) A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
f) CONVERSION RIGHTS FOR DIVORCED SPOUSES
g) COORDINATION OF BENEFITS AND SERVICES

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

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan D]".
New Rule, R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).

EXHIBIT E

(RESERVED)

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
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).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan E]".

EXHIBIT F

[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS POLICY
[Plan Name]

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 2016

POLICY ANNIVERSARIES: [January 1 of each year beginning in 2017.]

PREMIUM DUE DATES: [Effective Date, and the 1st day of the month beginning with February 2016.]

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

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

[Secretary President]

[Dividends are apportioned each year.]
SEH B,C,D,E

[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

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Definitions
Employee Coverage
[Dependent Coverage]
[Preferred Provider Organization Provisions]
[Point of Service Provisions]
[Exclusive Provider Organization Provisions]
[Appeals Procedure]
[Continuation of Care]
Health Benefits Insurance
[Utilization Review Features]
[Specialty Case Management]
[Centers of Excellence Features]
Exclusions
Continuation Rights
[Conversion Rights for Divorced Spouses]
[Effect of Interaction with a Health Maintenance Organization Plan]
Coordination of Benefits and Services
Benefits for Automobile Related Injuries
Medicare as Secondary Payor

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN B]**

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

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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. However, [Carrier] 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:

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	[40% or 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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN C]**

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

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE

second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]]

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. However, [Carrier] 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:

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

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

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

CLASS(ES)

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.

Emergency Room Copayment (waived if admitted within 24 hours)	[amount consistent with N.J.A.C. 11:22-5.5]]

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. However, [Carrier] 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:

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **[PLAN E]**

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

CLASS(ES)

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits)	NONE
For all other Covered Charges	
Per Covered Person	[deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours)	[amount consistent with N.J.A.C. 11:22-5.5]]

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. However, [Carrier] 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:

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	10%

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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies [other than Prescription Drugs] for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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)**

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

CLASS(ES)

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] 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
second surgical opinion	NONE
Pre-natal visits	NONE
for all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]
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 not to exceed three 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)	[amount consistent with N.J.A.C. 11:22-5.5]]

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

[Urgent Care Services Copayment	an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] 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.

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

For Preventive Care:	0%
[For Prescription Drugs	[30%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] Year.
The Non-**Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person Maximum.]]

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)**

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

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
Pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]

[Calendar] [Plan] Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Second Surgical Opinion and Prescription Drugs

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

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 for all other Covered Charges	NONE
Per Covered Person	[Dollar amount not to exceed three 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)	[amount consistent with N.J.A.C. 11:22-5.5]]

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

[Urgent Care Services Copayment an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] 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.

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

For Preventive Care:	0%
For pre-natal visits	0%
[For Prescription Drugs	[30%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%• if treatment, services or supplies are given by a
Non-Network Provider	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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person Maximum.]]

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)**

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

CLASS(ES)

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
For pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]

[Calendar] [Plan] Year Cash Deductible

For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

Emergency Room Copayment (waived if admitted within 24 hours)	[amount consistent with N.J.A.C. 11:22-5.5]]

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

[Urgent Care Services Copayment	an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] 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.

The **Coinsurance** for this Policy is as follows:	
For Preventive Care:	0%
For Prescription Drugs	[30%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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] [Plan] 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] [Plan] Year.

The **Network Maximum Out of Pocket** for this Policy is as follows:	
Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES

EXAMPLE INDEMNITY POS (using Plan D, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

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

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
second surgical opinion	NONE
Pre-natal visits	NONE

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

Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement	[an amount not to exceed $500 per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per [Calendar] [Plan] Year]

]

Exception: If the Hospital is a Network facility, the Hospital will be paid as a Network Facility regardless of whether the admitting Practitioner is a Network Practitioner.

[Calendar] [Plan] Year Cash Deductibles

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

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

[Calendar] [Plan] Year Cash Deductible

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 not to exceed three 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) [amount consistent with N.J.A.C. 11:22-5.5]]

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

[Urgent Care Services Copayment an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] 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.

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

For Preventive Care:	0%
[For Prescription Drugs	30%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	20%

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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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 Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Deductible and Coinsurance shall count toward the

Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person Maximum.]]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE EPO (using Plan D, with Copayment on specified services)**

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

[Note to carriers: This Example EPO schedule page illustrates some services and supplies that are not listed on other sample schedule pages. The services and supplies specifically listed on the Example EPO page may be included on other schedule pages. The same is true for text illustrated on other example pages.]

CLASS(ES)

[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment	
For Preventive Care	**NONE**
Second surgical opinion	NONE
Pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Primary Care Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
All other Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement	[an amount not to exceed $500 up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per [Calendar] [Plan] Year][Hospital Outpatient Surgery [an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Ambulatory Surgical Center Copayment	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Facility Outpatient (non-surgical)	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Therapeutic Manipulation	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Telemedicine Visits	[dollar amount not to exceed $50]]
[E-Visits	[dollar amount not to exceed $50]]
[Virtual Visits	[dollar amount not to exceed $50]]

[Calendar] [Plan] Year Cash Deductibles

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

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]
Emergency Room Copayment (waived if admitted within 24 hours)	[amount consistent with N.J.A.C. 11:22-5.5]]
[Urgent Care Services Copayment	an amount consistent with N.J.A.C. 11:22-5.5(a)11]

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the **Network** Maximum Out of Pocket has been reached with respect to **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.

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

For Preventive Care:	0%
For Prescription Drugs:	[20% - 50%]
For Durable Medical Equipment:	[20% - 50%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	[10% - 50%]

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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES

Example EPO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges. A Tiered Network design may be included with any of the plans that have network benefits.)

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

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

SERVICES	[Tier 1]	[Tier 2]]
[Calendar] [Plan] Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Pre-natal visits	NONE	NONE
Prescription Drugs		[$250]
[Generic Drugs]		[$50]
[Preferred Drugs]		[$100]
[Non-Preferred Drugs]		[$150]
[All other Covered Charges		
Per Covered Person	$500	$1,500
Per Covered Family	$1,000	$3,000]
(Use above deductible for separate accumulation..)		
[All other Covered Charges		
Per Covered Person	$1,000	$2,000
Per Covered Family	$2,000	$4,000
(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)		

SERVICES **Copayment** applies after the Cash Deductible is satisfied	**[Tier 1]**	**[Tier 2]]**
Preventive Care	NONE	NONE
Primary Care Physician Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Pre-natal visits	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]	N/A See Tier 2	50% [10%] [20%] [50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Covered Person	$2,000	$4,350
Per Covered Family	$4,000	$8,700]
(Use above for separate accumulation.)		
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Covered Person	$2,000	$6,350
Per Covered Family	$4,000	$12,700]

SERVICES	[Tier 1]	[Tier 2]]
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		

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.

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] [Plan] 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 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] [Plan] Year.

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) **[PLANS B, C, D, E]**

Daily Room and Board Limits

During a Period of Hospital Confinement

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

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

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

[Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- [Speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Nutritional Counseling
- [Certain Prescription Drugs [including Specialty Pharmaceuticals][and certain injectable drugs]
- [Complex Imaging Services]

[V2500 – V2599 Contact Lenses]]

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

[Plans B, C, D, E (Continued)]

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

Charges for therapeutic manipulation per [Calendar] [Plan] Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits

Charges for physical or occupational therapy per [Calendar] [Plan] Year (combined benefits)	30 visits
See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits

Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.

Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits

Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.

[Charges for Preventive Care per [Calendar] [Plan] Year as follows:
(Not subject to Copayment, Cash Deductible or Coinsurance)

• for a Covered Person who is a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1	$750 per Covered Person*
• for all [other] Covered Persons	$500 per Covered Person*

* The $750 and $500 limits do not apply to services from a Network Practitioner.]

Note to carriers: Include the asterisks and asterisked text for plans with network benefits. If the policy is issued as an EPO and provides network only coverage omit this section from the schedule.

Charges for hearing aids for a Covered Person Age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Home Health Care	60 visits per [Calendar] [Plan] Year
[Facility Charges by Non-Network Ambulatory Surgical Center	[amount not less than $2,000] per [Calendar] [Plan] Year]

[Non-Network Vision benefits for a Covered Person through the end of the month in which he or she turns age 19 are subject to the following limits:

Exam	$30 per [Calendar] [Plan] Year
Single Vision lenses	$25 per [Calendar] [Plan] Year
Bifocal lenses	$35 per [Calendar] [Plan] Year
Trifocal lenses	$45 per [Calendar] [Plan] Year
Lenticular lenses	$45 per [Calendar] [Plan] Year
Elective Contact lenses	$75 per [Calendar] [Plan] Year
Medically Necessary Contact lenses	$225 per [Calendar] [Plan] Year
Frames	$30 per [Calendar] [Plan] Year]

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are set forth on the [rate quote] for this Policy for the effective date shown on the face page of the Policy.

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

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
[a. the forms shown in the Policy Index as of the Effective Date:
b.] the Policyholder's application, a copy of which is attached to this Policy;
[c.] any riders, [endorsements] or amendments to this Policy; and
[d.] the individual applications, if any, of the persons covered.

STATEMENTS
No statement will void the insurance under this Policy, or be used in defense of a claim hereunder unless:
a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person.
All statements will be deemed representations and not warranties.

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

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

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

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

No change in this Policy is valid unless the change is shown in one of the following ways:
[a. It is shown in an endorsement on it signed by an officer of [Carrier].]
[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].
[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:
• is signed by an officer of [Carrier]; and
• is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.
[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

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

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

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

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

Premium Refunds
If one or more of the premiums paid include charges for an Employee [and or Dependent] whose coverage has ended before the due date of that premium, any refund of premium will depend on whether the Employee contributed toward the premium payment or whether it was paid in full by the Policyholder.

If the Employee contributed toward the premium payment, [Carrier] will not refund the premium and coverage will continue in force through the end of the period for which premium has been contributed by the Employee.

If the premium was paid in full by the Policyholder, any refund of premium will depend on whether claims were incurred during the period of no more than two months for which refund is requested. If no claims have been incurred [Carrier] will refund premiums paid for a maximum of two months prior to the date [Carrier] receives written notice from the Policyholder that the Employee's [and or Dependent's] coverage has ended. If claims have been incurred during the period prior to [Carrier's] receipt of written notice that the Employee [and Dependent's] coverage has ended, [Carrier] shall not be required to refund premium to the Policyholder.

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier] [[XYZ] for remittance to [Carrier]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at a [Carrier's] [XYZ's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Policyholder is liable to pay premiums for the time this Policy is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for policies issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Policy will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for policies issued inside the SHOP]*

[REINSTATEMENT

If the premium has not been paid before the end of the grace period, this Policy automatically terminates as of the last day of the grace period. The Policyholder may make written request to the [Carrier] that the Policy be reinstated. If the [Carrier] accepts the request for reinstatement, the Policyholder must pay all unpaid premiums back to the date premium was last paid. Such payment is subject to the premium rate then in effect and to [the payment of the reinstatement fee as established by the [Carrier.] [an interest charge, determined as a percentage of the unpaid amount. The percentage will be determined by the [Carrier] but will not be more than the maximum percentage allowed by law.]]

PREMIUM RATE CHANGES

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

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

[Carrier] will give the Policyholder 60 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Policyholder;
c. the Employee is covered under Medicare;
d. the Employee is covered under Medicaid or NJ FamilyCare;
e. the Employee is covered under Tricare; or
f. the Employee is covered under another [individual or] group health benefits plan.

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.
[Note to carriers: Variable text in item f applies to SHOP policies only.]

CLERICAL ERROR - MISSTATEMENTS

Except as stated below, neither clerical error nor programming or systems error by the Policyholder, nor [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Policyholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision, such return of premium will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

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

[Carrier] has the right to non-renew this Policy on the Policy Anniversary following the date the Policyholder no longer meets the requirements of a Small Employer as defined in this Policy. The Policyholder must certify to [Carrier] the Policyholder's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If the Policyholder fails to do this, [Carrier] retains the right to non-renew this Policy as of the Policyholder's Policy Anniversary.

[Carrier] has the right to non-renew this Policy on the Policy Anniversary Date subject to advance written notice to the Policyholder for the following reasons:
a) [Carrier] ceases to do business in the small group market;
b) [Carrier] ceases offering and non-renews a particular type of Health Benefits Plan in the small group market; or
c) the Board terminates a standard plan or a standard plan option.
The advance written notice for non-renewal for the reasons stated in items a and b above shall comply with the requirements of N.J.A.C. 11:21-16. The advance written notice required for the reason stated in item c above shall be the same as the notice requirements for item b above.

[Carrier] has the right to non-renew this Policy on the Policy Anniversary Date subject to 60 days advance written notice to the Policyholder for the following reasons:
a) the Policyholder moves outside the state of New Jersey;
b) [less than [75%] of the Policyholder's eligible full-time Employees are covered by this Policy. If an eligible full-time Employee is not covered by this Policy because:
   1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
   2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Policyholder.
   3. The Employee is covered under Medicare;
   4. The Employee is covered under Medicaid or NJ FamilyCare;
   5. The Employee is covered under TRICARE; or
   6. The Employee is covered under another group [or individual] health benefits plan;
   [Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.
   [Note to carriers: Use the variable text in item 6 for SHOP policies only.]
c) the Policyholder does not contribute at least 10% of the annual cost of the Policy; or
d) the Policyholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Covered Person

Note: A Policyholder will not be non-renewed for failure to meet the participation or contribution requirement if the renewal date coincides with the Employer Open Enrollment Period.

If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. The Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. [Carrier] is not required to honor a request for a retroactive termination of this Policy. For prospective termination requests, this Policy will end on the date requested. The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force. [Carrier] shall give notice of the date of termination to the Policyholder no more than 30 days following the date of the termination.

Immediate cancellation will occur if the Policyholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Policy. Please refer to the **RetroactiveTermination of a Covered Person's Coverage** provision which also addresses the consequences of fraud or misrepresentation.

RETROACTIVE TERMINATION OF A COVERED PERSON'S COVERAGE
[Carrier] will not retroactively terminate a Covered Person's coverage under this Policy after coverage under this Policy take effect unless the Covered Person performs an act, practice, or omission that constitutes fraud, or unless the Covered Person makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation [Carrier] will provide at least 30 days advance written notice to each Covered Person whose coverage will be retroactively terminated.

If a Policyholder continues to pay the full premium for a Covered Person who is no longer eligible to be covered the Policyholder may request a refund of premium as explained in the Premium Refunds provision. If [Carrier] refunds premium to the Policyholder the refund will result in the retroactive termination of the Covered Person's coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

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

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

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

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

EMPLOYEE'S CERTIFICATE
[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:
a. to whom [Carrier] pays benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

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

[Responsibilities of the [Policyholder]:
As used in this provision "SBC" means the Summary of Benefits and Coverage required by federal law.

a. The [Policyholder] shall deliver to all Eligible Persons, including [Carrier] Covered Persons, the SBC for the group health benefits provided under this [Policy], as required by federal law or regulations, in a timely and appropriate manner. The [Policyholder] shall distribute SBCs under this provision: to all Eligible Persons with any written application materials for enrollment (including open enrollment); to special enrollees; [and] upon renewal of coverage [; and upon request].

b. The [Policyholder] shall distribute applicable SBCs, upon request and at any other times, to Eligible Persons who are not currently enrolled with [Carrier].

c. The [Policyholder] agrees to certify to [Carrier] upon [Carrier's] request that the [Policyholder] has provided the SBC as required under the [Policy] and by law. The [Policyholder] agrees to submit information upon [Carrier's] request showing that the [Policyholder] has provided the SBC, as required under the [Policy] and by law.]

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

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

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

CONFORMITY WITH LAW
Any provision of this Policy which is in conflict with the laws of the state in which the Policy is issued, 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.

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

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

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

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

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

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

RECORDS - INFORMATION TO BE FURNISHED
[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

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

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

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

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

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

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

When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss. If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

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

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

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.

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

Affiliated Company means a company as defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the [Covered Person] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.
Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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

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

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

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

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

[**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.]

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

[Carrier] will recognize it if:
a) it carries out its stated purpose under all relevant state and local laws; or
b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) it is approved for its stated purpose by Medicare.

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

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

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

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

[Complex Imaging Services means any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

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

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

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

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

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

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

[Dependent means an Employee's:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended; and the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.
b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

An Employee's " Dependent child" includes:
a) his or her legally adopted children,
b) his or her step-child,
c) his or her foster child
d) the child of his or her civil union partner, [and]
e) [the child of his or her domestic partner, and] [
f)]children under a court appointed guardianship.
[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[Dependent's Eligibility Date means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

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

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

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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 an Employee [or Dependent], as the context in which the term is used suggests.

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.

[Employee means a Full-Time bona fide Employee (25 hours per week) of the Policyholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[Employee means an Employee of the Policyholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

Employee Open Enrollment Period means the 30-day period each year designated by the Policyholder during which:

a) Employees and Dependents who are eligible under the Policy but who are Late Enrollees may enroll for coverage under the Policy; and

b) Employees and Dependents who are covered under Policy may elect coverage under a different policy, if any, offered by the Policyholder.

Employee's Eligibility Date means the later of:
a) the date of employment;
b) [the day] after any applicable Waiting Period ends; or
c) [the day] after any applicable Orientation Period ends.

Employer means [ABC Company].

Employer Open Enrollment Period means the period from November 15 through December 15 each year beginning in 2014.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the Covered Person's Enrollment Date does not change.

[E-Visit means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.]

Experimental or Investigational means [Carrier] determines a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

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

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

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

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

1. The American 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. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means a place [Carrier] is required by law to recognize which:
a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation.

Full-Time means a normal work week of [25] [30] or more hours. Work must be at the Policyholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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.

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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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

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

Illness 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. Illness includes Mental Illness.

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

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

[**Legend Drug** means any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[**Mail Order Program** means a program under which a [Covered Person] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

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

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

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

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

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

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

Mental Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[[**Network**] **Provider** means a Provider which has an agreement [directly or indirectly] with [Carrier] to provide covered services or supplies. The Employee will have access to up-to-date lists of [Network] Providers.]

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

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

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

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

[**Non-Preferred Drug** means a drug that has not been designated as a Preferred Drug.]

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.

[**Orientation Period** means a period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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.

[**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:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[**Participating Pharmacy** means a licensed and registered pharmacy operated by [Carrier] or with whom [Carrier] has signed a pharmacy services agreement.]

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

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

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

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. §1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.] [For more information regarding the services for which [Carrier] requires Pre-Approval, consult the website at [www.xxx.com]]

[**Preferred Drug** means a Prescription Drug that; a) has been designated as such by either Us, or a third party with which [Carrier] contracts, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Covered Persons, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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

Preventive Care. As used in this Policy preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the [Covered Person];
b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Covered Person];
c) Evidence–informed preventive care and screenings for [Covered Persons] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Covered Persons] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

[Referral means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct 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. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

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

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

[Small Employer means

a) , in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.] OR

b) in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.
The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.
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.

Special Enrollment Period means a period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Policyholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Policyholder.

[**Specialty Pharmaceuticals** are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

Substance Abuse means abuse of or addiction to drugs or alcohol.

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

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

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

[**Telemedicine** means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a Covered Person.

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.

Triggering Event means the following dates:
a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.

d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

Total Disability or Totally Disabled means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.
Urgent Care means care for a non-life threatening condition that requires care by a Provider within 24 hours.

[**Virtual Visit** means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.]

[**Waiting Period** means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

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

[**You, Your and Yours** means the Employer.]

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of this Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are [Actively at Work] Full-Time Employees[.]
[In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,][Carrier] will not insure an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder's Policy Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under this Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Policy and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.
But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under this Policy because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under this Policy for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under this Policy within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
This Policy has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Policyholder by that date, are covered under this Policy from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Policyholder by that date, are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and]working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.]

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

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

If the Employee does this more than [30] days after the Employee's Eligibility Date, [Carrier] will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Employee was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under this Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Policy will end one year from the date the person's coverage under this Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Policy.]
Exception: If the coverage under this Policy is richer than the coverage under the Policyholder's old plan, this Policy will provide coverage for services and supplies related to the disabling condition. This Policy will coordinate with the Policyholder's old plan, with this Policy providing secondary coverage, as described in the Coordination of Benefits and Services provision.

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

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Policy.
c) the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d) the last day of the period for which required payments are made for the Employee, subject to the **Payment of Premiums - Grace Period** section.

[DEPENDENT COVERAGE

Policyholder Election
A Policyholder that elects to make Dependent coverage available under the Policy may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Policyholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Policy is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits
An Employee's eligible Dependents are the Employee's:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended)
the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.
b) Dependent children who are under age 26.

Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

An Employee's "unmarried Dependent child" includes:
a) his or her legally adopted children,
b) his or her step-child,
c) his or her foster child,
d) the child of his or her civil union partner, [and]
e) [the child of his or her domestic partner, and] *[Note to carriers: if domestic partner coverage is not included the following item becomes item e.]*
f) children under a court appointed guardianship.
[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

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

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

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

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

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. ["[Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent and agrees to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy and stated at that time that, such waiver was because they were covered under another group plan and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

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

In addition, if an Employee initially waived coverage under this Policy for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

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

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder's Policy Anniversary date following enrollment.

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

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:

a) the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.

[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

The coverage under this Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Policy will end one year from the date the person's coverage under this Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Policy.

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth without additional premium. Health benefits may be continued beyond such 31-day period as stated below:

a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee must notify [Carrier] of the birth of the newborn child as soon as possible in order that [Carrier] may properly provide benefits under this Policy.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

- give written notice to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

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, the child will be a Late Enrollee

When Dependent Coverage Ends

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

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

PREFERRED PROVIDER ORGANIZATION PROVISIONS

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

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers. The up-to date lists will be furnished automatically, without charge.

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

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

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

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

See the Schedule for specific benefit levels, payment rates and payment limits.
If an Employee has any questions after reading his or her certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]

POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization. A female Covered Person may visit her OB/GYN without supervision or coordination from the PCP.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies. [Network benefits are shown as [Tier 1] and [Tier 2].]
d) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if the PCP refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and [Carrier] is fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers even though they are not authorized by the PCP, the Covered Person will be eligible for Non-Network Benefits where the [XYZ] provider's charges and the Covered Person's liability are limited to the negotiated fee for the service or supply.
A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing]. For a discretionary change, 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.

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

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

Non-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. Except as stated below, for services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Non-Network Benefits. Exception: If a [Covered Person] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Emergency Services
If a Covered Person requires services for Urgent Care or an Emergency which occurs inside the PO Service Area, he or she must notify his or her PCP within 48 hours or as soon as reasonably possible thereafter.

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

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

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

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What [Carrier] pays is subject to all the terms of this Policy.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[no referral required]

Definitions
a) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization. A female Covered Person may visit her OB/GYN without supervision or coordination from the PCP.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)
Under this Policy a Covered person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO for example, by providing referrals to specialists. Even if a PCP is selected, a Covered person can choose any specialist he or she wants to use. [Whether or not a PCP is selected and office visit to a PCP who qualifies as a PCP is subject to the PCP copayment.] [But if a Covered Person goes to a Practitioner other than a selected PCP a higher copayment will generally apply.]

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

Emergency Services
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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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 EPO.]

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if referral is required.]

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

e) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
f) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Practitioner (PCP)
The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for benefits under this Policy.

[Carrier] will provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. If the PCP obtains approval from [Carrier] and refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and [Carrier is] fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers but have not been authorized by the PCP, the Covered Person will not be eligible for benefits.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

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

Emergency Services

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]]

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[CONTINUATION OF CARE

[Carrier] shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from [Carrier's] 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 [Carrier]. 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 [Carrier's] 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.

[Carrier] 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, [Carrier] 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, [Carrier] 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, [carrier] 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 [Carrier].

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with [Carrier]. 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 [Carrier].

If a Covered Person is admitted to a health care Facility on the date this Policy is terminated, [Carrier] 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.

[Carrier] shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of [Carrier's] 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. [Carrier] 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 [Carrier].

If [Carrier] refers a Covered Person to a Non-Network provider, the service or supply shall be covered as a network service or supply. [Carrier] is 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: [Carrier] 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 Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

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

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

[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] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before [Carrier] pays 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, [Carrier] pays 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] [Plan] Year.
Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before [Carrier] pays 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, [Carrier] pays 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] [Plan] 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 [Carrier] pays is based on all the terms of this Policy.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance and Premium Rates.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 2] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] 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 [Carrier] pays is based on all the terms of this Policy.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before [Carrier] pays benefits for [Tier 1] and [Tier 2] Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays 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] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] 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 [Carrier] pays is based on all the terms of this Policy.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a covered person to be in benefit for further Tier 1 covered charges and is also applied toward the satisfaction of the Tier 2 deductible.)

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a [Calendar] [Plan] Year, [Carrier] pays 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] [Plan] Year. What [Carrier] pays is based on all the terms of the Policy.]

[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] [Plan] Year. Once two Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Network Provider, [Carrier] pays 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] [Plan] 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] [Plan] Year. Once two Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Non-Network Provider, [Carrier] pays 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] [Plan] Year.

What [Carrier] pays is based on all the terms of this Policy.]
[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each [Calendar] [Plan] Year.

Tier 1 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 1 individual deductible limit amount in a [Calendar] [Plan] Year. Once this Tier 1 Family Deductible is met in a [Calendar] [Plan] Year, We provide coverage for all Tier 1 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the [Calendar] [Plan] Year.

Tier 2 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 and Tier 2 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 2 individual deductible limit amount in a [Calendar] [Plan] Year. Once this Tier 2 Family Deductible is met in a [Calendar] [Plan] Year, We provide coverage for all Tier 1 and Tier 2 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: The above text may be used for plans that feature Tier 1 and Tier 2.]

[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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] 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] [Plan] Year.]]
[Note to Carriers: Use this Maximum Out of Pocket text for a pure indemnity plan]

[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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Once two Covered Persons in a family meet their individual Maximum Out of Pocket, no other 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] [Plan] Year.]]

[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] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] 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] [Plan] Year.]]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network. Omit the Non-Network text if the plan is an EPO.]

[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] [Plan] 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] [Plan] Year.

[Once two Covered Persons in a family meet their individual Maximum Out of Pocket, no other 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] [Plan] Year.]]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance and Premium Rates.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 2] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 1] Network or [Tier 2] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.
Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] covered services and supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Covered Person must have Covered Charges that exceed the per Covered Person Cash Deductible before [Carrier] pays any benefits to the Covered Person 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 the Covered Person while insured can be used to meet the Cash Deductible.

Once the per Covered Person Deductible is met, [Carrier] pays benefits for other Covered Charges above the Deductible amount incurred by the Covered Person, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy including benefit limitations and exclusion provisions.

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, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.

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 and Copayments 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 or Copayments will be required for such Covered Person for the rest of the Calendar Year.

In the case coverage which is other than single coverage, for a Covered Person, the per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments 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 or Copayments 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text for single deductible, family deductible, and MOOP if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. . See the Schedule for these limits.

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

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

If This Plan Replaces Another Plan
The Policyholder who purchased this Policy may have purchased it to replace a plan the Policyholder had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Policyholder's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which this Policy starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Policy would have paid benefits for the charges if this Policy had been in effect:
c) the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d) this Policy takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.

The Covered Person may have satisfied part of the eligibility Waiting Period under the Policyholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:
a) the Employee was employed by the Policyholder on the date the Policyholder's old plan ended: and
b) this Policy takes effect immediately upon termination of the prior plan.

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

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

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

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

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

COVERED CHARGES
This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.
Hospital Charges
[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, [Carrier] covers 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, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

[Carrier] provides childbirth and newborn care coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by [Carrier].]
If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special care Unit shown in the Schedule.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment[, subject to this Policy's **Emergency Room 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 [Carrier] pays for Hospital charges.

[Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay the Copayment shown in the Schedule, 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 judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. [Carrier] also provides 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
[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

Extended Care or Rehabilitation Charges
[Subject to [Carrier's] Pre-Approval][Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.
[[Carrier] 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 [Carrier] provided that benefits would otherwise be payable under this Policy.]

Home Health Care Charges
[Subject to [Carrier's] Pre-Approval,] [W][w]hen home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals 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. [Carrier] does 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.

Benefits for Home health Care are provided for no more than 60 visits per Calendar [Plan] Year.

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

Practitioner's Charges for Non-Surgical Care and Treatment
[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does 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.

[Carrier] covers 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. [Carrier] also covers treatment of the physical complications of mastectomy, including lymphedemas.

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 [Carrier] authorizes coverage for such multi-stage procedure. In addition, [Carrier] 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.

Second Opinion Charges
[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
[Carrier] covers charges made by a dialysis center for covered dialysis services.

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

Hospice Care Charges
[Subject to [Carrier] Pre-Approval,][Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

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

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

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

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

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

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

Mental Illness or Substance Abuse
[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Mental Illness or Substance Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

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

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

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

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

Anesthetics and Other Services and Supplies
[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches [Carrier] covers 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, [Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
[Carrier] covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

[[Carrier] 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 the [Carrier's] 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 [Carrier's] network clinical laboratory.

[[Carrier] will pay the Hospital's clinical laboratory for the laboratory services at the same rate [Carrier] would pay a Network clinical laboratory for comparable services.]

Ambulance Charges
[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
[Subject to [Carrier's] Pre-Approval.][Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, [and with [Carrier's] Pre-Approval,] [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:
a) 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.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

[[Carrier] will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.]

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

Treatment of Wilm's Tumor
[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of this Policy.

Nutritional Counseling
[Subject to [Carrier] Pre-Approval,][Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

[[Carrier] will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.]

Food and Food Products for Inherited Metabolic Diseases
[Carrier] 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
[Carrier] covers 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. [Carrier] covers 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.
[Carrier] may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[[Subject to [Carrier] Pre-Approval, for certain Prescription Drugs]][Carrier] covers drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American 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 [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.
And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[[[Carrier] has identified certain Prescription Drugs [including Specialty Pharmaceuticals] for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. [Carrier] will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.]

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact [Carrier] to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact [Carrier] to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. [Carrier] will review the Pre-Approval request within the time period allowed by law. If [Carrier] gives Pre-Approval, [Carrier] 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 [Carrier] does 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 managed care plan)

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact [Carrier] to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after [Carrier] makes 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 [Carrier] does 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)

[If a Covered Person purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, [Carrier] will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Covered Person is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the Provider states "Dispense as Written" on the prescription the Covered Person will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Covered Person] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Policy pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Covered Person is insured. What [Carrier] pay[s] is subject to all the terms of the Policy.]

[A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. [Carrier] will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Covered Person's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the[Covered Person.

[Carrier] shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Covered Person may follow the Appeals Procedure set forth in the Policy. In addition, the Covered Person may appeal a denial to the Independent Health Care Appeals Program.]

The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and
c) needed to treat an Illness or Injury covered under this Policy.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill [which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]
b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and
c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

[[Carrier] will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by [Carrier.]]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[[Carrier] will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Covered Person for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Covered Person prior to dispensing the drug.]
[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

Supplies to Administer Prescription Drugs
[Carrier] covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

Orally Administered Anti-Cancer Prescription Drugs
As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Policy.

[[Carrier] covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs. [Carrier] covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Covered Person is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.]

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The Covered Person must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the Covered Person may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Policy. Upon receipt of such a claim [Carrier] will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Policy would have provided if the Covered Person had received intravenously administered or injected anti cancer medications [from the Network or Non-Network Practitioner, as applicable] to determine which is more favorable to the Covered Person in terms of copayment, deductible and/or coinsurance. If the Policy provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment deductible and coinsurance is more favorable to the Covered Person. If a Covered Person paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti cancer medications the Covered Person will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
[Carrier] covers 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. [Carrier] 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.

[Carrier] does 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.]

Clinical Trial
The coverage described in this provision applies to Covered Persons who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. [Carrier] provides coverage for the clinical trial if the Covered Person's practitioner is participating in the clinical trial and has concluded that the Covered Person's participation would be appropriate; or the Covered Person provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
[Carrier] provides coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

[Carrier] will not deny a qualified Covered Person participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. [Carrier] will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and

services furnished in connection with participation in the clinical trial. [Carrier] will not discriminate against the Covered Person on the basis of the Covered Person's participation in the clinical trial.

Dental Care and Treatment
This Dental Care and Treatment provision applies to all Covered Persons.
[Carrier] covers:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury 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 does [Carrier] cover orthodontic treatment.

[Dental Benefits

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, [Carrier] covers the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19 when services are provided by a [Network] provider.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

<u>Diagnostic Services</u>

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused
b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
    1. fixed – unilateral and bilateral
    2. removable – bilateral only
    3. recementation of fixed space maintainer
    4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth

c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
   1. Gingivectomy and gingivoplasty
   2. Gingival flap including root planning
   3. Apically positioned flap
   4. Clinical crown lengthening
   5. Osseous surgery
   6. Bone replacement graft – first site and additional sites
   7. Biologic materials to aid soft and osseous tissue regeneration
   8. Guided tissue regeneration
   9. Surgical revision
   10. Pedicle and free soft tissue graft
   11. Subepithelial connective tissue graft
   12. Distal or proximal wedge
   13. Soft tissue allograft
   14. Combined connective tissue and double pedicle graft
b) Non-Surgical Periodontal Service
   1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
   2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
   3. Full mouth debridement to enable comprehensive evaluation
   4. Localized delivery of antimicrobial agents
c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
   1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
   2. Flexible base denture including any clasps, rests and teeth
   3. Removable unilateral partial dentures or dentures without clasps are not considered
c) Overdenture – complete and partial
d) Denture adjustments –6 months after insertion or repair
e) Denture repairs – includes adjustments for first 6 months following service
f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
h) Precision attachment, by report
i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   2. Obturator prosthesis: surgical, definitive and modifications
   3. Mandibular resection prosthesis with and without guide flange
   4. Feeding aid
   5. Surgical stents
   6. Radiation carrier
   7. Fluoride gel carrier
   8. Commissure splint
   9. Surgical splint
   10. Topical medicament carrier
   11. Adjustments, modification and repair to a maxillofacial prosthesis
   12. Maintenance and cleaning of maxillofacial prosthesis
j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
   Covered services include: implant body, abutment and crown.
k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
   1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
   2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
   3. Considerations and requirements noted for single crowns apply
   4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
   5. Abutment teeth must be periodontally sound and have a good long term prognosis
   6. Repair and recementation
l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body

3. Partial ostectomy/sequestrectomy
4. Maxillary sinusotomy

m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
2. Manipulation under anesthesia
3. Condylectomy, discectomy, synovectomy
4. Joint reconstruction
5. Services associated with TMJD treatment require prior authorization

o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

p) Arthroscopy

q) Occlusal orthotic device – includes placement and removal to same provider

r) Surgical and other repairs
1. Repair of traumatic wounds – small and complicated
2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition

b) Interceptive treatment for the primary and transitional dentition

c) Minor treatment to control harmful habits

d) Continuation of transfer cases or cases started outside of the program

e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.

f) Orthognathic Surgical Cases with comprehensive orthodontic treatment

g) Repairs to orthodontic appliances

h) Replacement of lost or broken retainer

i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
    - Hospital or ambulatory surgical center call
        - For cases that are treated in a facility.
        - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
        - General anesthesia and outpatient facility charges for dental services are covered
        - Dental services rendered in these settings by a dentist not on staff are considered separately
    - Office visit for observation – (during regular hours) no other service performed
f) Drugs
    - Therapeutic parenteral drug
        - Single administration
        - Two or more administrations - not to be combined with single administration
    - Other drugs and/or medicaments – by report
g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
    - Limited - (per visit)
    - Complete (regardless of the number of visits), once in a lifetime
k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as explained in the Explanation of Brackets. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]
For a Covered Person who is severely disabled or who is a Child under age 6, [Carrier] covers:
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)
[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, with respect to coverage of TMJ [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

[Carrier] will cover charges for:
a) one baseline mammogram for a female Covered Person– who is 40 years of age
b) one mammogram, every year, for a female Covered Person age 40 and older; and
c) a mammogram at the ages and intervals the female Covered Person's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Covered Person who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram [Carrier] will cover charges for:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, 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.] [Note to Carriers; Include if policy includes limited non-network benefits.]

Colorectal Cancer Screening Charges
[Carrier] covers 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, [Carrier] will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

[Carrier] 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.] [Note to Carriers; Include if policy includes limited non-network benefits.]

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

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

Subject to the stated limits, [Carrier] covers the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient [Carrier] covers 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 [Carrier] Pre-Approval,]][Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
g. *Speech Therapy* -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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] Year.

[[Carrier] 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 [Carrier] provided that benefits would otherwise be payable under this Policy.]

j.*Infusion Therapy* –[subject to [Carrier] Pre-Approval,]the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. [[Carrier] will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by [Carrier] 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, to services provided while a [Covered Person] is confined in a Facility or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
[Carrier] provides coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability [Carrier] provides coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
c) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Covered Person's primary diagnosis is autism, in addition to coverage for the therapy services as described above, [Carrier] also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. [Carrier] may request additional information if necessary to determine the coverage under the Policy. [Carrier] may require the submission of an updated treatment plan once every six months unless [Carrier] and the treating physician agree to more frequent updates.

If a Covered Person:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a Covered Charge under this Policy. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

Fertility Services

[Subject to [Carrier] Pre-Approval][Carrier] covers charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in this Policy. [Carrier] covers charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Policy.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment.

[But [Carrier] limits what [Carrier] pays each [Calendar] [Plan] Year to:

a) $750 per Covered Person for a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1;
b) $500 per Covered Person for all other Covered Persons.

These charges are not subject to any Copayment, Cash Deductible or Coinsurance.] *[Note to Carriers: Include only for policies that provide non-network benefits if the carrier chooses to apply the limits to non-network benefits.]*

Immunizations and Lead Screening

[Carrier] 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.

Hearing Aids

[Carrier] covers charges for medically necessary services incurred in the purchase of a hearing aid for a Covered Person age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

Newborn Hearing Screening

[Carrier] covers 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, [Carrier] covers charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Vision Screening [Carrier] covers 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.

Vision Benefit Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, [Carrier] covers the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19.. [Carrier] covers one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period.

[Carrier] covers one pair of lenses, for glasses or contact lenses, in a 12 month period. [Carrier] covers one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

[Carrier] covers charges for a one comprehensive low vision evaluation every 5 years. [Carrier] covers low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Transplant Benefits
[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich

[Subject to [Carrier] Pre-Approval,] [B] [b]reast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **[[Carrier] will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.]**
- j) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

k)Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

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 medical costs associated with the donation. [Carrier] does not cover costs for travel, accommodations or comfort items.

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has 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 [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

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

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

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, 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 [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, 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" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 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. 11:24A-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
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency 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. [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

[REQUIRED PRE-SURGICAL REVIEW

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

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

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

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].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or 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, [[Carrier] reduces what it pays for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.
Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

[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 [Carrier] 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 the [Carrier] offers to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: [Carrier] has 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) Substance Abuse
l) Mental Illness
m) any other Illness or Injury determined by [DEF] or [Carrier] 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) [Carrier].
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 [Carrier], [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] [Plan] Year maximums.

Exclusion
Specialty Case Management does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.
"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

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

EXCLUSIONS

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

[Abortion, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]

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

The amount of any charge which is greater than an ***Allowed Charge***.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

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

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

Completion of claim forms.

[Preventive contraceptive services and supplies that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or an Eligible Organization as defined under 45 C.F.R. 147.131, as amended]

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 learning disabilities except as otherwise stated in this Policy.

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 or as otherwise covered under the Policy.

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 as otherwise covered under the Policy; 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 the Employee's ***family***: spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal. .

Except as stated in the Hearing Aids and Newborn Hearing Screening provisions, 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. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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.

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.

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 following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.

e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed

g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

h) Charges for a Prescription Drug which is to be taken by or given to the [Covered Person], in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home or similar institution
- a provider' office.

i) Charges for:

- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

m) Charges for any drug used in connection with baldness.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by a [Covered Person] taking part in a riot or other civil disorder; or the

o)[Covered Person] taking part in the commission of a felony.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

q) Charges for drugs dispensed to a [Covered Person] while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by the [Covered Person's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] [is/are] legally required to pay it, [Carrier] will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the [Policy.]

t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.

u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Covered Persons with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

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) 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.
e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
• travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
• business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or
[Subject to [Carrier] Pre-Approval,] [E][e]ligibility 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 [Carrier] are Non-Covered Charges.]
Stand-by services required by a Provider.

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

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

[Telephone consultations. [except as stated in the Practitioner's Charges for Non-Surgical Care and Treatment provision].]

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*** or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area..

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 Practitioner's Charges for Surgery section of this Policy and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A Covered Person who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

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

If a Covered Person elects to continue his or her group health benefits under this Policy's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice
Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:
a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:
a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period ofcreditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.
A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.
If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to [the Carrier] within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.
For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Policyholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Policy [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:

a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:

a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or termination of the domestic partnership], the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN
HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy If the Employer does the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP
Date Group Health Benefits Insurance Ends
Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 30 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY
Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

Request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in]the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.
COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Covered Person] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Policy] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows [Carrier] to coordinate what [Carrier] pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Policy] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.
When this [Policy] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, [Carrier] will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: An amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Covered Person] is covered by this [Policy] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Covered Person] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Covered Person's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:
a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Covered Person] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Covered Person] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN
[Carrier] considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Covered Person] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Covered Person] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Covered Person] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Covered Person] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 Allowed Charge (AC) 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 an Allowed Charge is called an " AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Covered Person] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that then HMO or EPO 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 and "EPO" refers to Exclusive Provider Organization.

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Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPO 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.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) this Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and 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 separate automobile policies and has made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.
If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if this Policy had been primary.

Medicare
If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how this Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.
Option (A) - The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary
When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a Covered Person who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age;
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease; or
c) A Covered Person who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and

b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary Plan. This Policy is the secondary Plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
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.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2013 d.038, effective January 24, 2013.
See: 45 N.J.R. 107(b), 45 N.J.R. 332(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT G

[Carrier] HMO PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)CONTRACT
[Plan Name]

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [January 1, 2016]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 2017]

PREMIUM DUE DATES: [Effective Date, and the 1st day of the month beginning with February 2016.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier], in consideration of the application for this Contract and the payment of premiums as stated herein, agrees to arrange [or provide] services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

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

[Secretary President]

[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]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are set forth on the [rate quote] for this Contract for the effective date shown on the face page of the Contract.

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."

This Contract's classifications, and the coverages and amounts which apply to each class are shown below:

CLASS(ES)
[All eligible employees]

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] [PLAN] YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS[/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT Maximum Copayment [dollar amount equal to 10 times the per day copayment]/[Calendar] [Plan] Year. Unlimited days.	[$100 to $500] Copayment/day for a maximum of 5 days/admission.
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	[at the option of the carrier,$50, $75 or $100] Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours)
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment and Coinsurance, if any.	
[URGENT CARE	[amount consistent with N.J.A.C. 11:22-5.5(a)]]
SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit
HOME HEALTH CARE	60 visits, if Pre-Approved; amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment per [day] [visit].
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	$0 Copayment
THERAPEUTIC MANIPULATION 30 visits/[Calendar] [Plan] Year	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit; maximum
PRE-ADMISSION TESTING	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with Copayments consistent with N.J.A.C. 11:22-5.5(a).]
PRIMARY CARE PROVIDER **For services other than Preventive Care**	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
[SERVICES **(OUTSIDE HOSPITAL)**	
[TELEMEDICINE VISITS	[dollar amount not to exceed $50]]
[E-VISITS	[dollar amount not to exceed $50]]
[VIRTUAL VISITS	[dollar amount not to exceed $50]]
PREVENTIVE CARE	$0 copayment
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	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
SPECIALIST SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
SKILLED NURSING FACILITY/EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; amount consistent with N.J.A.C. 11:22-5.5(a)Copayment per day.
THERAPY SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
Speech and Cognitive Therapy (Combined), maximum30 visits per [Calendar] [Plan] Year See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Physical and Occupational Therapy (Combined) maximum 30 visits per [Calendar] [Plan] Year See below for the separate benefits available under the Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Note: The 30-visit limit does not apply to the treatment of autism.	
Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Note: The 30-visit limit does not apply to the treatment of autism.	
[COMPLEX IMAGING SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]]
[ALL OTHER] DIAGNOSTIC SERVICES	.
INPATIENT	$0 Copayment
(OUTPATIENT)	amount consistent with N.J.A.C. 11:22-5.5(a)] 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] [Plan] Year per [Member], unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT	
For Preventive Care	NONE
For all other Primary Care Provider Visits	[amount consistent with N.J.A.C. 11:22-5.5(a)]
] per visit	
Maternity (pre-natal care)	NONE
For Prescription Drugs	[Copayments consistent with N.J.A.C. 11:22-5.5]
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER [CALENDAR] [PLAN] YEAR	
•For Primary Care Provider Visits including Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•Second Surgical Opinion	NONE
•for all other Covered Services and Supplies	
•Per Covered Person	Dollar amount not to exceed deductible permitted by 45 CFR 156.130(b)]
• [Per Covered Family	[Dollar amount which is two times the individual Deductible.]
COINSURANCE	
For Preventive Care	0%
Prescription Drugs	50%

[Vision Benefits (for Covered Persons through the end of the month in which the Member turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Member turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]

For all other services and supplies to which a Copayment does not apply	[10% - 50%, in 5% increments]
For all services and supplies to which a Copayment applies	None

EMERGENCY ROOM COPAYMENT [amount consistent with N.J.A.C. 11:22-5.5]
Copayment/visit/Member (credited toward Inpatient admission if admission occurs within 24 hours as the result of the emergency).
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

[URGENT CARE [amount consistent with N.J.A.C. 11:22-5.5(a)]]

MAXIMUM OUT OF POCKET
Maximum Out of Pocket means the annual maximum dollar amount that a Member Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a [Calendar] [Plan] 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 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] [Plan] Year.

6,850 or amount permitted by 45 C.F.R. 156.130
The **Maximum Out of Pocket** for this Contract is as follows:

- Per Member per [Calendar] [Plan] Year — [An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]
- Per Family per [Calendar] [Plan] Year — [Dollar amount equal to two times the per Member Maximum.]

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

SCHEDULE OF SERVICES AND SUPPLIES
Example HMO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges.)

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

SERVICES	[Tier 1]	[Tier 2]]
[Calendar] [Plan] Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Pre-natal visits	NONE	NONE
Prescription Drugs		[$250]
[Generic Drugs]		[$50]
[Preferred Drugs]		[$100]
[Non-Preferred Drugs]		[$150]
[All other Covered Services and Supplies		
Per Member	$1,000	$1,500
Per Covered Family	$2,000	$3,000]

SERVICES *(Use above deductible for separate accumulation..)* [All other Covered Services and Supplies	**[Tier 1]**	**[Tier 2]]**
Per Member	$1,000	$2,500
Per Covered Family	$2,000	$5,000
(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)		
Copayment applies after the Cash Deductible is satisfied		
Preventive Care	NONE	NONE
Primary Care Provider Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Pre-natal visits	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]	N/A See Tier 2	50% [10%] [20%] [50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Member	$2,000	$4,400
Per Covered Family	$4,000	$8,800]
(Use above for separate accumulation.)		

SERVICES	[Tier 1]	[Tier 2]]
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below)		
Per Member	$2,000	$6,850 or amount permitted by 45 C.F.R. 156.130
Per Covered Family	$4,000	$12,700]
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		

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

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] [Plan] 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 Member 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] [Plan] Year.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	60 visits per [Calendar] [Plan] Year, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Speech and Cognitive Therapy (Combined) See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per [Calendar] [Plan] Year
Physical and Occupational Therapy (Combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per [Calendar] [Plan] Year
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits per [Calendar] [Plan] Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits per [Calendar] [Plan] Year
Therapeutic Manipulation	30 visits per [Calendar] [Plan] 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 PROVIDER [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.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

ALLOWED CHARGE. Means an amount that is not more than the [lesser of:
• the] allowance 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 an Allowed Charge under this Contract.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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.]

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

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.
BOARD. The Board of Directors of the New Jersey Small Employer Health Benefits Program.
CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[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].]

[COMPLEX IMAGING SERVICES. Any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and [Carrier].

CONTRACTHOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies. **NOTE:** The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, 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 EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract.

Read the entire Contract to find out what We limit or exclude.

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

[DEPENDENT.
An Employee's:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986(COBRA), Pub. L. 99-272, as subsequently amended; and
- The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

An Employee's " Dependent child" includes his or her legally adopted child, his or her step-child, his or her foster child, the child of his or her civil union partner, [and] [,the child of his or her domestic partner , and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.
At Our discretion, We can require proof that a person meets the definition of a Dependent.]

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

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 sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We 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 as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Contractholder, or the date coverage begins under this Contract for a [Member], as the context in which the term is used suggests.

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.

[EMPLOYEE. A Full-Time bona-fide Employee (25 hours per week) of the Contractholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[EMPLOYEE. An Employee of the Contractholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

EMPLOYEE OPEN ENROLLMENT PERIOD. The 30-day period each year designated by the Contractholder during which:
a) Employees and Dependents who are eligible under the Contract but who are Late Enrollees may enroll for coverage under the Contract; and
b) Employees and Dependents who are covered under Contract may elect coverage under a different policy, if any, offered by the Contractholder.

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment;
b) [the day] after any applicable waiting period ends; or
c) [the day] after any applicable Orientation Period ends.

EMPLOYER. [ABC Company].

EMPLOYER OPEN ENROLLMENT PERIOD. The period from November 15 through December 15 each year beginning in 2014.

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the [Member's] Enrollment Date does not change.

[E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and [Members] who are established patients of the Provider.

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.

FULL-TIME. A normal work week of [25] [30] or more hours. Work must be at the Contractholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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 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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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 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 the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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. Illness includes Mental Illness.

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

INJURY 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.

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

[LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[MAIL ORDER PROGRAM. A program under which a [Member] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

[MAINTENANCE DRUG. Only a Prescription Drug used for the treatment of chronic medical conditions.]

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 (includes Covered Employee[and covered Dependents, if any)].

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Usto provide Covered Services or Supplies. The Employee will have access to up-to-date lists of [Network] Providers.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in this Contract.

NON- [NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

[NON-PREFERRED DRUG. A drug that has not been designated as a Preferred Drug.]

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.

[ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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.

[PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[PARTICIPATING PHARMACY. A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

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 [or the Care Manager] Determine if the cause(s) of the confinements are the same or related.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. § 1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

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. For more information regarding the services for which We require Pre-Approval, consult the website at [www.xxx.com]]

[PREFERRED DRUG. A Prescription Drug that; a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Members, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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.

. As used in the Contract preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

PRIMARY CARE PROVIDER (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.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

[REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Provider [or Health Center] [or Care Manager] in conformance with our policies and procedures that direct 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."

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, 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.

[SMALL EMPLOYER. Means:

a) In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of

whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year; OR

b) In connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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)].

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Contractholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Contractholder.

[SPECIALTY PHARMACETICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.
a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care;
d) any of the procedures designated by the Current Procedural Terminology Codes as surgery.

[TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].

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.

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

TRIGGERING EVENT. The following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.
d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

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

[VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the [Member] and the Provider.]

[WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees[who are in an eligible class and] who live, work or reside in the Service Area will be eligible if
the Employees are [Actively at Work] Full-Time Employees.

[In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,] We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason

for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Contract and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s],and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee must enroll under this Contract within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under this Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under this Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under this Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form. *[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]*

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
This Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under this Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under this Contract. But, if this Contract uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or number of work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and] working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, We will postpone the start of his or her coverage until he or she returns to Active Work.]

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

The Employee must elect to enroll and agree to make the required payments if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the Effective Date of an Employee's coverage.
If the Employee does this more than [30] days after the Employee's Eligibility Date, We will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:
a) the Employee was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.]
Exception: If the coverage under this Contract is richer than the coverage under the Contractholder's old plan, this Contract will provide coverage for services and supplies related to the disabling condition. This Contract will coordinate with the Contractholder's old plan, with this Contract providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends
An Employee's coverage under this Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Contract.
c) the date this Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) [the date] for which required payments are not made for the Employee, subject to the **Payment of Premiums - Grace Period** section.
e) [the date] an Employee no longer lives, works or resides in the Service Area.]

[DEPENDENT COVERAGE

Contractholder Election
A Contractholder that elects to make Dependent coverage available under the Contract may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Contractholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Contract is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits
[Except as stated below, an] [An] Employee's eligible Dependents are:
a) The Employee's legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law, with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1996 (COBRA), Pub. L. 99-272, as subsequently amended); and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.
b) the Employee's Dependent children who are under age 26.

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

[Exception: Any dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children, Step-Children, Foster Children
An Employee's " Dependent children" include the Employee's legally adopted children, his or her step-children, his or her foster children, the child of his or her civil union partner, [and] [,the child of his or her domestic partner, and] children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

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

The child will stay eligible as long as the child is and remains 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 depends on the Employee for most of his or her support and maintenance; and
c) the child became covered by this Contract or any other policy or contract before the child reached the age limit and stayed continuously covered after reaching such limit.

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

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

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.
Coverage will take effect as of the date required pursuant to the court order.

In addition, if an Employee initially waived coverage under this Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for an Employee's dependent coverage to begin the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of this Contract, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents[and agrees to make any required payments].
If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the [30] days after the Newly Acquired Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.
A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

The coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.

Newborn Children
We will cover an Employee's 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:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee 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.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

1) give written notice to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth.]

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, the child will be a Late Enrollee
When Dependent Coverage Ends:
A Dependent's coverage under this Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date this Contract ends;
[d)]. the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. at 12:01 a.m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Dependent spouse, the date the spouse moves his or her permanent residence outside the Service Area.]

EXTENDED HEALTH BENEFITS
If this Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under this Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of this Contract.

We do not cover services, supplies or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's coverage under this Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.
TERMINATION FOR CAUSE If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:
a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the[Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any identification card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes 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, including but not limited to; theft, damage to [Our] [Network Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeal Procedures We establish.

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider 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 Provider 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 Provider [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 Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Provider.

[Members] select a Primary Care Provider 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 Provider initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Provider selection. [If a [Member] fails to select a Primary Care Provider, We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Provider, [Members] can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Provider 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.

[NETWORK
The Member will have access to given up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]]

IDENTIFICATION CARD

The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES

In the event that due to circumstances not within Our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Our [Network] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

[REFERRAL FORMS

A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Provider.

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 Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.]

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.

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, the Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of 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 Provider or a Provider referred in writing by the Primary Care Provider 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 **Providers** 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. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[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 instance 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 Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

The Cash Deductible
Each [Calendar] [Plan] 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] [Plan] 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 Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of this Contract.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)

[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] [Plan] 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 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] [Plan] Year.]

[Once two Members in a family meet their individual 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] [Plan] Year.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network or [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable [copayment or] Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any [copayment or] Coinsurance, for the rest of that [Calendar] [Plan] Year.

Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible plus Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which this Contract starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Contract would have provided coverage for the charges if this Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

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 Provider's office[selected by a [Member], or elsewhere [upon prior written Referral by a [Member]'s Primary Care Provider]:
1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
2. **Home visits** by a [Member]'s Primary Care Provider.
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 Provider and Pre-Approved by Us.
7. **Procedures and Prescription Drugs to enhance fertility,** except where specifically excluded in this Contract. [Subject to Pre-Approval] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8. **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network.

Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.

9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **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. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]

[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] Network Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee 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.

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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 Provider 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) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

21). Orally Administered Anti-Cancer Prescription Drugs As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

[We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the [Member] is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs.

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The [Member] must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the [Member] may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Contract would have provided if the [Member] had received intravenously administered or injected anti cancer

medications from the Network to determine which is more favorable to the [Member] in terms of copayment, deductible and/or coinsurance. If the Contract provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment deductible and coinsurance is more favorable to the [Member]. If a [Member] paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti cancer medications the [Member] will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

22) **Vision Benefit** Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

23) **Mammogram Coverage**
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office 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 Provider].

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written [from a [Member]'s Primary Care Provider,] 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 childbirth and newborn 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.

We also cover 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.

20. The following transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestines.
21. Allogeneic bone marrow transplants.
[22. 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.]
[22 or23.] 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;
[23. or 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.]
[24 or 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 MENTAL ILLNESS OR SUBSTANCE ABUSE.** We cover treatment Mental Illness or Substance 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 Provider [or the Care Manager]]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered [without prior written Referral by a [Member]'s Primary Care Provider] in the event of an Emergency as Determined by Us.

1. A [Member]'s Primary Care Provider 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 Provider [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 Provider 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.]
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.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Network Provider [upon prior written Referral by a [Member]'s Primary Care Provider [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.
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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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 or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

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(g) DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
c) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.
Member Person:
a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a Covered Service under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

(h) **HOME HEALTH CARE.** The following Services are covered [upon prior written referral from a [Member]'s Primary Care Provider]. 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.

Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

(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 Provider. 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.

I(k) **DENTAL CARE AND TREATMENT.**

Dental benefits available to all [Members]

The following services are covered for all [Members] when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Provider]. 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.

[Dental Benefits available to [Members] through the end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

<u>Diagnostic Services</u>

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c) Tests and Examinations

d) Viral culture

e) Collection and preparation of saliva sample for laboratory diagnostic testing

f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
   2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
   3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.

- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening
    5. Osseous surgery
    6. Bone replacement graft – first site and additional sites
    7. Biologic materials to aid soft and osseous tissue regeneration
    8. Guided tissue regeneration
    9. Surgical revision
    10. Pedicle and free soft tissue graft
    11. Subepithelial connective tissue graft
    12. Distal or proximal wedge
    13. Soft tissue allograft
    14. Combined connective tissue and double pedicle graft
b) Non-Surgical Periodontal Service
    1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
    2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
    3. Full mouth debridement to enable comprehensive evaluation
    4. Localized delivery of antimicrobial agents
c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
    1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
    2. Flexible base denture including any clasps, rests and teeth
    3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial
d) Denture adjustments –6 months after insertion or repair
e) Denture repairs – includes adjustments for first 6 months following service
f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
h) Precision attachment, by report
i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   2. Obturator prosthesis: surgical, definitive and modifications
   3. Mandibular resection prosthesis with and without guide flange
   4. Feeding aid
   5. Surgical stents
   6. Radiation carrier
   7. Fluoride gel carrier
   8. Commissure splint
   9. Surgical splint
   10. Topical medicament carrier
   11. Adjustments, modification and repair to a maxillofacial prosthesis
   12. Maintenance and cleaning of maxillofacial prosthesis
j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
   Covered services include: implant body, abutment and crown.
k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
   1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
   2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
   3. Considerations and requirements noted for single crowns apply
   4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
   5. Abutment teeth must be periodontally sound and have a good long term prognosis
   6. Repair and recementation
l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis

j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects
   9. Frenectomy and frenoplasty
   10. Excision of hyperplastic tissue and pericoronal gingiva
   11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
   12. Emergency tracheotomy
   13. Coronoidectomy
   14. Implant – mandibular augmentation purposes
   15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment

g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
    - Hospital or ambulatory surgical center call
        - For cases that are treated in a facility.
        - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
        - General anesthesia and outpatient facility charges for dental services are covered
        - Dental services rendered in these settings by a dentist not on staff are considered separately
    - Office visit for observation – (during regular hours) no other service performed
f) Drugs
    - Therapeutic parenteral drug
        - Single administration
        - Two or more administrations - not to be combined with single administration
    - Other drugs and/or medicaments – by report
g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
    - Limited - (per visit)
    - Complete (regardless of the number of visits), once in a lifetime
k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted if a stand-alone dental plan is bought. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]
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 Provider]. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(m) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior [by a [Member's] Primary Care Provider]. We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] 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, with 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) CLINICAL TRIAL The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

[Abortion, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]

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

The amount of any charge which is greater than an **Allowed Charge**.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a[Member].

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

Completion of claim forms.

[Preventive contraceptive services and supplies that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]

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 learning disabilities except as otherwise stated in this Contract.

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 or as otherwise covered under this Contract.

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 as otherwise covered under this Contract; 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 the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), donor sperm, surrogate motherhood; and b) Prescription Drugs not eligible under the Prescription Drugs section of the Contract; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

Except as otherwise stated in the Hearing Aids and Newborn Hearing Screening provisions, 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. Exception: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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.**

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.

[[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed

g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home or similar institution
- a provider' office.

i) Charges for:

- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

m) Charges for any drug used in connection with baldness.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the

o)Member taking part in the commission of a felony.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

q) Charges for drugs dispensed to a Member while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract

t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.

u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

[Any service provided without prior written Referral by the [Member]'s **Primary Care Provider,** except as specified in this Contract.]

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

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) 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.

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. [except as stated in the Outpatient Services provision].]

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**, or an act of war, if the Illness or Injury occurs while the Member is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area...

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 surgery section of this Contract and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Contract] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Us to coordinate what We pay or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Contract] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.

When this [Contract] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: 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 .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Member] is covered by this [Contract] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Member] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Member's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Member] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Member] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period, the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Member] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Member] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Member] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Member] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 Allowed Charge (AC), 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 an Allowed Charge is called an "AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Member] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that the HMO, EPO 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 and "EPO" refers to Exclusive Provider Organization.

Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPO 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.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the[Member] is insured or covered for services under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

AFFILIATED COMPANIES
If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

An Employee of the Contractholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Contract. That Employee's service with multiple Employers will be treated as service with that one.
The Contractholder must notify Us in writing when a company stops being an Affiliated Company. As of this date, this Contract will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Contractholder or another Affiliated Company as eligible Employees.

AMENDMENT
The Contract may be amended, at any time, without a [Member]'s consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT
No assignment or transfer by the Contractholder 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
Except as stated below, neither clerical error nor programming or systems error by the Contractholder, nor Us in keeping any records pertaining to coverage under this Contract, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Contractholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision, such return of premium will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

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.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

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

Responsibilities of the [Contractholder]:
As used in this provision "SBC" means the Summary of Benefits and Coverage required by federal law.

a. The [Contractholder] shall deliver to all Eligible Persons, including [Carrier] [Members], the SBC for the group health benefits provided under this [Contract], as required by federal law or regulations, in a timely and appropriate manner. The [Contractholder] shall distribute SBCs under this provision: to all Eligible Persons with any written application materials for enrollment (including open enrollment); to special enrollees; [and] upon renewal of coverage [; and upon request].

b. The [Contractholder] shall distribute applicable SBCs, upon request and at any other times, to Eligible Persons who are not currently enrolled with [Carrier].

c. The [Contractholder] agrees to certify to [Carrier] upon [Carrier's] request that the [Contractholder] has provided the SBC as required under the [Contract] and by law. The [Contractholder] agrees to submit information upon [Carrier's] request showing that the [Contractholder] has provided the SBC, as required under the [Contract] and by law.

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.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Contractholder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to the Contractholder for attachment to this Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PARTICIPATION REQUIREMENTS

At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Contract because:

a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder;
c. the Employee is covered under Medicare;
d. the Employee is covered under Medicaid or NJ FamilyCare;
e. the Employee is covered under Tricare; or
f. the Employee is covered under another group [or individual] health benefits plan.

[Carrier] will count this person as being covered by this Contract for the purposes of satisfying participation requirements.
[Note to carriers: Variable text in item f applies to SHOP policies only.]

PREMIUM AMOUNTS

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

Premium Refunds

If one or more of the premiums paid include charges for an Employee [and or Dependent] whose coverage has ended before the due date of that premium, any refund of premium will depend on whether the Employee contributed toward the premium payment or whether it was paid in full by the Contractholder.

If the Employee contributed toward the premium payment, [Carrier] will not refund the premium and coverage will continue in force through the end of the period for which premium has been contributed by the Employee.

If the premium was paid in full by the Contractholder, any refund of premium will depend on whether claims were incurred during the period of no more than two months for which refund is requested. If no claims have been incurred [Carrier] will refund premiums paid for a maximum of two months prior to the date [Carrier] receives written notice from the Contractholder that the Employee's [and or Dependent's] coverage has ended. If claims have been incurred during the period prior to [Carrier's] receipt of written notice that the Employee [and Dependent's] coverage has ended, [Carrier] shall not be required to refund premium to the Contractholder.

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at [Our] [XYZ's] office [or to one of our authorized agents.] A premium payment is due on each premium due date stated on the first page of this Contract. The Contractholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Contractholder is liable to pay premiums for the time this Contract is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for contracts issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Contract will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for contracts issued inside the SHOP]*

[REINSTATEMENT

If the premium has not been paid before the end of the grace period, this Contract automatically terminates as of the last day of the grace period. The Contractholder may make written request to Us that the Contract be reinstated. If We accept the request for reinstatement, the Contractholder must pay all unpaid premiums back to the date premium was last paid. Such payment is subject to [the payment of the reinstatement fee as established by Us.] [an interest charge, determined as a percentage of the unpaid amount. The percentage will be determined by Us but will not be more than the maximum percentage allowed by law.]]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to prospectively change Premium rates as of any of these dates:

a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) any date that the extent or nature of the risk under the Contract is changed:
   1) by amendment of the Contract; or
   2) by reason of any provision of law or any government program or regulation;
d) at the discovery of a clerical error or misstatement as described below.

We will give You 60 days written notice when a change in the Premium rates is made.

RECORDS - INFORMATION TO BE FURNISHED

We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to Determine the premium rates and certify status as a Small Employer. All records of the Contractholder which bear on this Contract must be open to Us for Our inspection at any reasonable time.

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

The Contractholder will furnish Us the Employee [and Dependents] eligibility requirements of this Contract that apply on the Effective Date. Subject to Our approval, those requirements will apply to the Employee [and Dependent] coverage under this Contract. The Contractholder will notify Us of any change in the eligibility requirements of this Contract, but no such change will apply to the Employee [or Dependent] coverage under this Contract unless Pre-Approved by Us.

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

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 at the Contractholder's place of business.

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

We have the right to non-renew this Contract on the Contract Anniversary following the date the Contractholder no longer meets the requirements of a Small Employer as defined in this Contract. The Contractholder must certify to Us the Contractholder's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If the Contractholder fails to do this, We retain the right to non-renew this Contract as of the Contractholder's Contract Anniversary.

We have the right to non-renew this Contract on the Contract Anniversary date following advance written notice to the Contractholder for the following reasons:

a) We cease to do business in the small group market;
b) We cease offering and non-renew a particular type of Health Benefits Plan in the small group market; or
c) the Board terminates a standard plan or a standard plan option.

The advance written notice for non-renewal for the reasons stated in items a and b above shall comply with the requirements of N.J.A.C. 11:21-16. The advance written notice required for the reason stated in item c above shall be the same as the notice requirements for item b above.

We have the right to non-renew this Contract on the Contract Anniversary Date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves outside the state of New Jersey;
b) [less than [75%] of the Contractholder's eligible [full-time Employees are covered by this Contract. If an eligible a full-time Employee is not covered by this Contract because:
    1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
    2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder.
    3. The Employee is covered under Medicare;
    4. The Employee is covered under Medicaid or NJ FamilyCare;
    5. The Employee is covered under TRICARE; or
    6. The Employee is covered under another group [or individual] health benefits plan,

    [Carrier] will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;]
    [Note to carriers: Use the variable text in item 6 for SHOP policies only.]

c) the Contractholder does not contribute at least 10% of the annual cost of the Contract; or
d) the Contractholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Member

Note: A Contractholder will not be non-renewed for failure to meet the participation or contribution requirement if the renewal date coincides with the Employer Open Enrollment Period.

If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. The Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. We are not required to honor a request for a retroactive termination of this Contract. For prospective termination requests, this Contract will end on the date requested. The Contractholder is liable to pay premiums to Us for the time this Contract is in force. We shall give notice of the date of termination to the Contractholder no more than 30 days following the date of the termination.
Immediate cancellation will occur if the Contractholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Contract. Please refer to the **RetroactiveTermination of a [Member's] Coverage** provision which also addresses the consequences of fraud or misrepresentation.

RETROACTIVE TERMINATION OF A [MEMBER'S] COVERAGE
We will not retroactively terminate a [Member's] coverage under this Contract after coverage under this Contract take effect unless the [Member] performs an act, practice, or omission that constitutes fraud, or unless the [Member] makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation We will provide at least 30 days advance written notice to each [Member] whose coverage will be retroactively terminated.

If a Contractholder continues to pay the full premium for a [Member] who is no longer eligible to be covered the Contractholder may request a refund of premium as explained in the Premium Refunds provision. If We refund premium to the Contractholder the refund will result in the retroactive termination of the [Member's] coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

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;
[d)] the individual applications, if any, of all [Members.

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A [Member] who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

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

If a [Member] elects to continue his or her group health benefits under this Contract's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice
Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner)of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:
a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Contract ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.
To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union, [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;

f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to Us within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.
The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Contract [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;

3. acquires a Dependent;
4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare

b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS
If an Employee's marriage ends by legal divorce or annulment, or the employee's civil union is dissolved [or termination of the domestic partnership], the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health coverage ends. See **Exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage. or
c) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare. Benefits will be payable as specified in the COORDINATION OF BENEFITS AND SERVICES section of this Contract.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **COORDINATION OF BENEFITS AND SERVICES** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse

b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner]..

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, this Contract is the primary plan. This Contract is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and

b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if a ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
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).
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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2013 d.038, effective January 24, 2013.
See: 45 N.J.R. 107(b), 45 N.J.R. 332(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT H

(RESERVED)

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
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).
Repeal and New Rule, R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(a).
Section was "Exhibit H: Rider for Prescription Drug Insurance".
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Repealed by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Card/Mail/Pre-Approval/Preferred".

EXHIBIT I

(RESERVED)

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).
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit I: Rider for Mental and Nervous Conditions and Substance Abuse Benefits".

EXHIBIT J

(RESERVED)

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).
Repealed by R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(a).

EXHIBIT K

EXPLANATION OF BRACKETS

Plans B through E Policy and Certificate
(Appendix Exhibits F and W for Plans B – 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 PPO, EPO 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, POS or EPO)
h) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.
i) Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (SHOP).

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO or POS or EPO plans, explicit guidance is set forth in item 29 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 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. 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.
3. 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.
4. Deductible, Co-Insurance, and Copayments may be elected by the Employer, subject to the availability specified in regulation.
5. There are alternate PPO and POS schedule pages that allow carriers to use separate or common deductible and maximum out of pocket provisions. These features may be used, at the option of the carrier. There are corresponding provisions in the benefit provisions.
6. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in the PPO, POS and EPO descriptions and other coverage sections of the policy.
7. The list of services and supplies for which pre-approval is required includes two items, included in brackets: specified therapies 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.
8. The Reinstatement provision may be included or omitted, at the option of the carrier. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
9. 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.
10. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
11. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
12. 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.
13. The definition of Referral should be included in POS plans that require referrals.
14. 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.
15. 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.
16. 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 90 days and must satisfy the requirements of regulation. The text may address a date certain following a waiting period,

such as first of the month following 2months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.

17. 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.
18. The text describing provider compensation in the PPO and POS sections contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
19. The continuation of care text must be included in all plans that use networks.
20. The treatment of hemophilia provision includes variable text that would only be included in managed care plans.
21. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
22. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
23. 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.
24. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty.
25. The Specialty Case Management provision may be omitted. Carriers may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
26. 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.
27. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.
28. 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. 11:21-3(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.
    b. Include the specific page of text describing either the PPO, POS or the EPO mechanism, with specification of the name of the network or provider organization.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

29. The face page text may be modified to be consistent with a carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
30. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group plan.
31. Variable schedule data such as deductible, and copayment amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
32. The Payment of Premiums-Grace Period section may be omitted, at the carrier's option.
33. The definition of "You, Your and Yours" may be omitted by carriers that elect to refer to the employee as Employee, rather than use the personal "You". Throughout the text, the words "You," "Your" and "Yours" must be replaced with "Employee" terminology.

Plan HMO Contract and Evidence of Coverage
(Appendix Exhibits G and Y)

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.
e) 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.

f) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

g) Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (SHOP).

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. Copayments may be elected by the Employer, subject to the availability specified in regulation.
4. Deductible, coinsurance and maximum out of pocket provisions may be included for network benefits. 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. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in other coverage sections of the contract.
6. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. 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.
7. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE:** ALL plans issued by a Carrier must make the optional benefit available in the same manner.
8. The bracketed dispensing limit text contained in the prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
9. Eligible class references can be removed.
10. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 90 days and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 60 days. 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. Percentage participation requirement 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.
13. 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.
14. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
15. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
16. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
17. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

In addition to the above items, Carriers must consider the following in connection with the evidence of coverage forms:

18. The face page text may be modified to be consistent with a carrier's methods of evidence of coverage personalization. The evidence of coverage level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the document. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
19. The term "evidence of coverage" may be replaced with a similar term used to identify the document provided to employees covered under an employer's group plan.

Plan HMO-POS Contract and Evidence of Coverage
(Appendix Exhibits HH and II)

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 five ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].
2. Some areas of variability are noted with brief explanations within the text.
3. Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
4. Some areas of variability are subject to ranges specified in statute or regulation.
5. Some areas of variability are determined by Carrier elections. [Examples include terms to identify the member, network and non-network benefits.]
6. Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.
7. Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

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. 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. The forms define and use the terms "Network" or "In-Network" and "Non-Network" or "Out-of-Network." Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms. (Example: Participating, Non-Participating)
4. The forms define and use the term "Member." Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
5. The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
6. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
7. Copayment, deductible, coinsurance and maximum out of pocket amounts may be elected by the Contractholder, subject to the availability specified in regulation. The applicable schedule page and benefit provision text should be included, consistent with whether deductible and coinsurance provision applies to both network and non-network benefits or only to non-network benefits.
8. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in other coverage sections of the contract.
9. 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.
10. The definition of "Employer" should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
11. The "Waiting Period" provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed 90 days. The text may address a date certain following a waiting period, such as first of the month following 60 days. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
12. The date employee or dependent coverage begins or ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may begin as of the first of the month following any waiting period. Coverage may end immediately, or at the end of the month in which the termination event occurs.)
13. The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration, but may not be more restrictive to the member than stated in the form.
14. Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note*: All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
15. The bracketed dispensing limit text contained in the network prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
16. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
17. Carriers that wish to apply pre-approval requirements to non-network prescription drug coverage should include the variable pre-approval text.
18. The Utilization Review Features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Insurance, pursuant to N.J.A.C. 11:21-4.2.
19. The "Specialty Case Management" provision may be omitted. Carriers may provide for such "case management" administratively. If included in the form, the text must conform to the text of the standard form.
20. The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
21. Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
22. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
23. The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.

24. The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.
20. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

The following explanations apply only to the Evidence of Coverage.

1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
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).
Repeal and New Rule, R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).

EXHIBIT L

(RESERVED)

Repeal and New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit L: Patient Instructions for HCFA 1500".

EXHIBIT M

(RESERVED)

Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit M: Annual Family Profile and Claim Notice".

EXHIBIT N

(RESERVED)

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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Repealed by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Application for a Small Group Health Benefits [Policy]".

EXHIBIT O

(RESERVED)

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).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Repealed by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Employer Certification".

EXHIBIT P

(RESERVED)

EXHIBIT Q

(RESERVED)

Repeal and New Rule, R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Explanation of Brackets Small Employer Health Benefits".
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).
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit Q: Small Group Employer Benefits Enrollment [and Change Form] [and Pre-Existing Conditions Statement]".

EXHIBIT R

(RESERVED)

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

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Exhibit was "Enrollment Application and Change Form".

EXHIBIT S

(RESERVED)

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

Exhibit was "Health Maintenance Organization (HMO) Enrollment Application (and Change Form) Small Employer Health Benefits Plan for Employees and Dependants".

EXHIBIT T

[CARRIER]

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name _____

Employee Name _____ Social Security # _____
Last First MI

Marital Status: ___Single ___Married ___Widowed ___Divorced

Date of Employment _____ Date of Birth _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by [Carrier]. I refuse the following:

____ Employee, Spouse and Child(ren) coverage

____ Spouse coverage

____ Child(ren) coverage

Reason for Refusal (Please check all appropriate lines)

____ other Group Health Plan sponsored by this employer

____ other Group Health Plan sponsored by my spouse's employer

____ other Group Health Plan sponsored by another organization

____ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):
Policyholder Name: _____
Carrier: _____
Policy Number: _____

Policyholder Name: _____
Carrier: _____
Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within [30] days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within [30] days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become incligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form [and Pre-Existing Condition Statement], and coverage may be subject to a preexisting conditions exclusion.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date

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).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

EXHIBIT U

PART 1

(Reserved)

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).
Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Reinsuring Carrier Declaration".

PART 2

(Reserved)

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).

Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Risk-Assuming Carrier Declaration".

PART 3

(Reserved)

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

Repealed by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Part was "Risk-Assuming Carrier Application".

EXHIBIT V

(RESERVED)

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
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).
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).
Repeal and New Rule, R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Repealed by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Section was "Small Group Health Benefits [Certificate]".

EXHIBIT W

[Carrier] PLANS B, C, D, E
SMALL GROUP HEALTH BENEFITS [CERTIFICATE]
[Plan Name]

[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

[POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE;	01-01-16
[CALENDAR] [PLAN] YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$1,000
PER COVERED FAMILY:	$2,000
COINSURANCE:	20%
MAXIMUM OUT OF POCKET	
PER COVERED PERSON:	$3,000
PER COVERED FAMILY:	$6,000]

[Secretary President]

[Dividends are apportioned each year.]

[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]]

CERTIFICATE INDEX

SECTION	PAGE(S)
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General Provisions	
Claims Provisions	
Definitions	
Employee Coverage	
[Dependent Coverage]	
[Preferred Provider Organization Provisions]	
[Exclusive Provider Organization Provisions]	
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[Appeals Procedure]	
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SCHEDULE OF INSURANCE **[PLAN B]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and	
lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits NONE	
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]
Emergency Room Copayment (waived if admitted within 24 hours)	[amount consistent with N.J.A.C. 11:22-5.5]

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. However, [Carrier] will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	[40% or 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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered person maximum.]

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

SCHEDULE OF INSURANCE **[PLAN C]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care	NONE
for immunizations and	
lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits NONE	
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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. However, [Carrier] will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]

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

SCHEDULE OF INSURANCE **[PLAN D]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible	
for Preventive Care NONE	
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits NONE	
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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. However, [Carrier] will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

SCHEDULE OF INSURANCE **[PLAN E]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits NONE	
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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. However, [Carrier] will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
For all other Covered Charges	10%

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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum

]

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

[Calendar] [Plan] Year Cash Deductibles

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

for Preventive Care	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

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 not to exceed three 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)	[amount consistent with N.J.A.C. 11:22-5.5]

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

[Urgent Care Services Copayment	an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
[For Prescription Drugs	[30%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person Maximum.]]

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
Pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]

[Calendar] [Plan] Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Second Surgical Opinion and Prescription Drugs

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

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 not to exceed three 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) [amount consistent with N.J.A.C. 11:22-5.5]

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

[Urgent Care Services Copayment an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
Pre-natal visits	0%
[For Prescription Drugs	[30%]]

For all other services and supplies:
• if treatment, services or supplies are given by a Network Provider 10%
• if treatment, services or supplies are given by a Non-Network Provider 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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.
The **Network Maximum Out of Pocket** for the Policy is as follows:
Per Covered Person per [Calendar] [Plan] Year [An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year [Dollar amount equal to two times the per Covered Person maximum.]]
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] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] Year.
The **Non-Network Maximum Out of Pocket** for the Policy is as follows:
Per Covered Person per [Calendar] [Plan] Year [An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year [Dollar amount equal to two times the per Covered Person Maximum.]]
Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment
For Preventive Care **NONE**
Pre-natal visits NONE
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [an amount consistent with N.J.A.C. 11:22-5.5(a)]
[Calendar] [Plan] Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits
Per Covered Person [not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family [Dollar amount which is two times the individual Deductible.]]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

[Urgent Care Services Copayment an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] 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. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:
For Preventive Care: 0%
For Prescription Drugs [30%]

For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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] [Plan] 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] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

SCHEDULE OF INSURANCE **EXAMPLE INDEMNITY POS (using Plan D, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment	
For Preventive Care	**NONE**
second surgical opinion	NONE
Pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement	[an amount not to exceed $500 up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per [Calendar] [Plan] Year]

Exception: If the Hospital is a Network facility, the Hospital will be paid as a Network Facility regardless of whether the admitting Practitioner is a Network Practitioner.

[Calendar] [Plan] Year Cash Deductibles

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

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

[Calendar] [Plan] Year Cash Deductible

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 not to exceed three 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)	[amount consistent with N.J.A.C. 11:22-5.5]

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

[Urgent Care Services Copayment	an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:	
For Preventive Care:	0%
[For Prescription Drugs	30%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	20%

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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

The **Network Maximum Out of Pocket** for the Policy is as follows:	
Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed [$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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 Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

The Non-**Network Maximum Out of Pocket** for the Policy is as follows:	
Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person Maximum.]]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE EPO (using Plan D, with Copayment on specified services)
[Note to carriers: This Example EPO schedule page illustrates some services and supplies that are not listed on other sample schedule pages. The services and supplies specifically listed on the Example EPO page may be included on other schedule pages. The same is true for text illustrated on other example pages.]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment	
For Preventive Care	**NONE**
second surgical opinion	NONE
Pre-natal visits	NONE
For all other treatment, services and supplies given by a **Network** Provider	
Primary Care Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
All other Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement	[an amount not to exceed $500 up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per [Calendar] [Plan] Year][Hospital Outpatient Surgery [an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Ambulatory Surgical Center Copayment	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Facility Outpatient (non-surgical)	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Therapeutic Manipulation	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Telemedicine Visits	[dollar amount not to exceed $50]]
[E-Visits	[dollar amount not to exceed $50]]
[Virtual Visits	[dollar amount not to exceed $50]]

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

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

[Urgent Care Services Copayment an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the **Network** Maximum Out of Pocket has been reached with respect to **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.

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

For Preventive Care:	0%
For Prescription Drugs:	[20% - 50%]
For Durable Medical Equipment	[20% - 50%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10% - 50%]]

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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

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

Per Covered Person per [Calendar] [Plan] Year	[An amount not to exceed[$6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

SCHEDULE OF INSURANCE

Example EPO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges. A Tiered Network design may be included with any of the plans that have network benefits.)

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

SERVICES	[Tier 1]	[Tier 2]]
[Calendar] [Plan] Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Pre-natal visits	NONE	NONE
Prescription Drugs		[$250]
[Generic Drugs]		[$50]
[Preferred Drugs]		[$100]
[Non-Preferred Drugs]		[$150]

SERVICES	[Tier 1]	[Tier 2]]
[All other Covered Charges		
Per Covered Person	$500	$1,500
Per Covered Family	$1,000	$3,000]
(Use above deductible for separate accumulation..)		
[All other Covered Charges		
Per Covered Person	$1,000	$2,000
Per Covered Family	$2,000	$4,000
(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)		
Copayment applies after the Cash Deductible is satisfied		
Preventive Care	NONE	NONE
Primary Care Physician Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Pre-natal visits	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs	N/A See Tier 2	50%
[Generic Drugs]		[10%]
[Preferred Drugs]		[20%]
[Non-Preferred Drugs]		[50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Covered Person	$2,000	$4,350

SERVICES	[Tier 1]	[Tier 2]]
Per Covered Family	$4,000	$8,700]
(Use above for separate accumulation.)		
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below)		
Per Covered Person	$2,000	$6,850 or amount permitted by 45 C.F.R. 156.130
Per Covered Family	$4,000	$12,700]
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		

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.

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] [Plan] 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 has no further obligation to pay any

SCHEDULE OF INSURANCE (Continued) [PLANS B, C, D, E]
Daily Room and Board Limits

During a Period of Hospital Confinement

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

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

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

[Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- [Speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Nutritional Counseling
- [Certain Prescription Drugs] [including Specialty Pharmaceuticals][and certain injectable drugs]
- [Complex Imaging Services]
- [V2500 – V2599 Contact Lenses]]

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

[Plans B, C, D, E (Continued)]

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

Charges for therapeutic manipulation per [Calendar] [Plan] Year 30 visits

Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Charges for physical or occupational therapy per [Calendar] [Plan] Year (combined benefits)	30 visits
See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	

Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.	

Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.	

Charges for Preventive Care per [Calendar] [Plan] Year as follows:
(Not subject to Copayment, Cash Deductible or Coinsurance)

[• for a Covered Person who is a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1	$750 per Covered Person]*
• for all [other] Covered Persons	$500 per Covered Person*

* The $750 and $500 limits do not apply to services from a Network Practitioner.
Note to carriers: Include the asterisks and asterisked text for plans with network benefits.
If the policy is issued as an EPO and provides network only coverage omit this section from the schedule.

Charges for hearing aids for a Covered Person age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Home Health Care	60 visits per [Calendar] [Plan] Year

[Non-Network Vision benefits for a Covered Person through the end of the month in which he or she turns age 19 are subject to the following limits:

Exam	$30 per [Calendar] [Plan] Year
Single Vision lenses	$25 per [Calendar] [Plan] Year
Bifocal lenses	$35 per [Calendar] [Plan] Year
Trifocal lenses	$45 per [Calendar] [Plan] Year
Lenticular lenses	$45 per [Calendar] [Plan] Year
Elective Contact lenses	$75 per [Calendar] [Plan] Year
Medically Necessary Contact lenses	$225 per [Calendar] [Plan] Year
Frames	$30 per [Calendar] [Plan] Year]

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

GENERAL PROVISIONS

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

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

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier] [[XYZ] for remittance to [Carrier]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at a [Carrier's] [XYZ's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of this

Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Policyholder is liable to pay premiums for the time this Policy is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for policies issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Policy will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for policies issued inside the SHOP]*

CLERICAL ERROR - MISSTATEMENTS
Except as stated below, neither clerical error nor programming or systems error by the Policyholder, nor [Carrier] in keeping any records pertaining to coverage under the Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Policyholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision of the Policy, such return of premium will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

RETROACTIVE TERMINATION OF A COVERED PERSON'S COVERAGE
[Carrier] will not retroactively terminate a Covered Person's coverage under the Policy after coverage under the Policy take effect unless the Covered Person performs an act, practice, or omission that constitutes fraud, or unless the Covered Person makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation [Carrier] will provide at least 30 days advance written notice to each Covered Person whose coverage will be retroactively terminated.

If a Policyholder continues to pay the full premium for a Covered Person who is no longer eligible to be covered the Policyholder may request a refund of premium as explained in the Premium Refunds provision of the Policy. If [Carrier] refunds premium to the Policyholder the refund will result in the retroactive termination of the Covered Person's coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

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

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

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

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

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

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

CONFORMITY WITH LAW
Any provision of the Policy which is in conflict with the laws of the state in which the the Policy is issued, 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.

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

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

CLAIMS PROVISIONS

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

[NOTICE OF LOSS
A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.
When [Carrier] receives the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

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

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

PAYMENT OF CLAIMS
[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

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

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

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [Certificate].. Please read these definitions carefully. [Throughout this [Certificate], 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.

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

Affiliated Company means a company as defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the [Covered Person] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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

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

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by Medicare.
[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of the 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.]

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

[Carrier] will recognize it if:
a) it carries out its stated purpose under all relevant state and local laws; or
b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) it is approved for its stated purpose by Medicare.

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

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

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

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

[**Complex Imaging Services** means any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

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

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

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

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

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

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

[Dependent means Your:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended; and the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.
b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of the [Certificate].

Your " Dependent child" includes:
a) Your legally adopted children,
b) Your step-child, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner and] *[Note to carriers: if domestic partner coverage is not included the following item becomes item d.]*
e) children under a court appointed guardianship.

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

[Dependent's Eligibility Date means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

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 the Policy if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

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

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

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors as well as hearing aids which are covered through age 15. . Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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 the Policy for the Policyholder, or the date coverage begins under the Policy for an Employee [or Dependent], as the context in which the term is used suggests.

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.

[Employee means a Full-Time bona fide Employee (25 hours per week) of the Policyholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[Employee means an Employee of the Policyholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

Employee Open Enrollment Period means the 30-day period each year designated by the Policyholder during which:
a) Employees and Dependents who are eligible under the Policy but who are Late Enrollees may enroll for coverage under the Policy; and
b) Employees and Dependents who are covered under Policy may elect coverage under a different policy, if any, offered by the Policyholder.

Employee's Eligibility Date means the later of:
a) the date of employment;
b) [the day] after any applicable Waiting Period ends, or.
c) [the day] after any applicable Orientation Period ends.

Employer means [ABC Company].

Employer Open Enrollment Period means the period from November 15 through December 15 each year beginning in 2014.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the Covered Person's Enrollment Date does not change.

[E-Visit means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.]

Experimental or Investigational means [Carrier] determines a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

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

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

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

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

1. The American 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. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means a place [Carrier] is required by law to recognize which:
a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation.

Full-Time means a normal work week of [25] [30] or more hours. Work must be at the Policyholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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.

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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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

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

Illness 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. Illness includes Mental Illness.

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

Injury 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.

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

[Legend Drug means any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[Mail Order Program means a program under which a [Covered Person] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

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

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.
Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

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

Mental Health Center means a Facility which mainly provides treatment for people with Mental Illness. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.
Mental Illness means a behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[[Network] Provider means a Provider which has an agreement [directly or indirectly] with [Carrier] to provide covered services or supplies. The Employee will have access to up-to-date lists of [Network] Providers.]

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

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

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

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

[Non-Preferred Drug means a drug that has not been designated as a Preferred Drug.]

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.

[Orientation Period means a period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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.

[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:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

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

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

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

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

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. §1002(16)(B)). That is:

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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

Policyholder means the Employer who purchased the Policy.

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

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

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.] [For more information regarding the services for which [Carrier] requires Pre-Approval, consult the website at [www.xxx.com]]

[**Preferred Drug** means a Prescription Drug that; a) has been designated as such by either Us, or a third party with which [Carrier] contracts, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Covered Persons, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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

Preventive Care. As used in the Policy preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the [Covered Person];
b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Covered Person];
c) Evidence–informed preventive care and screenings for [Covered Persons] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Covered Persons] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies];; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic

devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

[Referral means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with [Carrier's] policies and procedures that direct 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. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

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

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

[Small Employer means:

a) in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.; OR

b) in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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.

Special Enrollment Period means a period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Policyholder's Policy; and

b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Policyholder.

[**Specialty Pharmaceuticals** are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

Substance Abuse means abuse of or addiction to drugs or alcohol.

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

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

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

[**Telemedicine** means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a Covered Person.

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.

Triggering Event means the following dates:
a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.
d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

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

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

[**Virtual Visit** means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.]

[**Waiting Period** means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

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

[You, Your and Yours means an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are [Actively at Work] Full-Time Employees.
[In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,][Carrier] will not insure an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder's Policy Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under the Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under the Policy and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.
But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under the Policy because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Policy for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Policy within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
The Policy has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Policyholder by that date, are covered under this Policy from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Policyholder by that date, are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under the Policy. But, if the Policy uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and]working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.]

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

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

If the Employee does this more than [30] days after the Employee's Eligibility Date, [Carrier] will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Policyholder who purchased the Policy purchased it to replace a plan the Policyholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date the Policy takes effect will initially be eligible for limited coverage under the Policy if:

a) the Employee was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the Policy takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under the Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Policy will end one year from the date the person's coverage under the Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Policy.]

Exception: If the coverage under the Policy is richer than the coverage under the Policyholder's old plan, the Policy will provide coverage for services and supplies related to the disabling condition. The Policy will coordinate with the Policyholder's old plan, with the Policy providing secondary coverage, as described in the Coordination of Benefits and Services provision.

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

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under the Policy.
c) the date the Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d) the last day of the period for which required payments are made for the Employee, subject to the **Payment of Premiums - Grace Period** section.

[DEPENDENT COVERAGE

Policyholder Election
A Policyholder that elects to make Dependent coverage available under the Policy may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Policyholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Policy is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are Your:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law, with respect to:
- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended)
- the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent children who are under age 26
Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of the [Certificate].

Your " Dependent child" includes:
a) your legally adopted children,
b) your step-children,
c) his or her foster child, [and]
d) the child of his or her civil union partner, [and]
e) [the child of his or her domestic partner and]
f) children under a court appointed guardianship.

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

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

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

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated 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. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage ends.

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Policy.[Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a) enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under the Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under the Policy and stated at that time that, such waiver was because they were covered under another group plan and the Employee now elects to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under the Policy, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

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

In addition, if an Employee initially waived coverage under the Policy for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under the Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. . An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder's Policy Anniversary date following enrollment.

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

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Policyholder who purchased the Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date the Policy takes effect will initially be eligible for limited coverage under the Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the Policy takes effect immediately upon termination of the prior plan.

The coverage under the Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Policy will end one year from the date the person's coverage under the Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Policy.

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth without additional premium. Health benefits may be continued beyond such 31-day period as stated below:

a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee must notify [Carrier] of the birth of the newborn child as soon as possible in order that [Carrier] may properly provide benefits under the Policy.

b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

- give written notice to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

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, the child will be a Late Enrollee.

When Dependent Coverage Ends

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

a) [the date] Employee coverage ends;

b) the date the Employee stops being a member of a class of Employees eligible for such coverage;

c) the date the Policy ends;

d) the date Dependent coverage is terminated from the Policy for all Employees or for an Employee's class.

e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

f) at 12:01 a. m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

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

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers. The up-to date lists will be furnished automatically, without charge.

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

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

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

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

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

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

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]

POINT OF SERVICE PROVISIONS

Definitions
a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies. [Network benefits are shown as [Tier 1] and [Tier 2].]
d)
e) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
f) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if the PCP refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and [Carrier] is fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers even though they are not authorized by the PCP, the Covered Person will be eligible for Non-Network Benefits where the [XYZ] provider's charges and the Covered Person's liability are limited to the negotiated fee for the service or supply.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

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

Non-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. Except as stated below, for services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Non-Network Benefits. Exception: If a [Covered Person] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Emergency Services
If a Covered Person requires services for Urgent care or an Emergency which occurs inside the PO Service Area, he or she must notify his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.
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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

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

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What [Carrier] pays is subject to all the terms of the Policy.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[no referral required]

Definitions
a) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)
Under this Policy a Covered person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO for example, by providing referrals to specialists. Even if a PCP is selected, a Covered person can choose any specialist he or she wants to use. [Whether or not a PCP is selected and office visit to a PCP who qualifies as a PCP is subject to the PCP copayment.] **[But if a Covered Person goes to a Practitioner other than a selected PCP a higher copayment will generally apply.]**

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

Emergency Services

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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 EPO.]

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if referral is required.]

Definitions
d) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
e) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
f) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Practitioner (PCP)
The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for benefits under this Policy.

[Carrier] will provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. If the PCP obtains approval from [Carrier] and refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and [Carrier is] fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers but have not been authorized by the PCP, the Covered Person will not be eligible for benefits.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

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

Emergency Services

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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 provided 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] Network are compensated, please call [Carrier] 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.]]

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[CONTINUATION OF CARE

[Carrier] shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from [Carrier's] 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 [Carrier]. 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 [Carrier's] 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.

[Carrier] 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, [Carrier] 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, [Carrier] 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, [carrier] 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 [Carrier].

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with [Carrier]. 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 [Carrier].

If a Covered Person is admitted to a health care Facility on the date the Policy is terminated, [Carrier] 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 the Policy, whichever occurs first.
[Carrier] shall not continue services in those instance in which the health care professional has been terminated based upon the opinion of [Carrier's] 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 the Policy. [Carrier] 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 [Carrier].

If [Carrier] refers a Covered Person to a Non-Network provider, the service or supply shall be covered as a network service or supply. [Carrier] is 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: [Carrier] payments will be reduced if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy.

BENEFIT PROVISION

[The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

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

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

[The 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] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before [Carrier] pays 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 the Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays 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] [Plan] Year.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before [Carrier] pays 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 the Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays 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] [Plan] Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet either Cash Deductible. What [Carrier] pays is based on all the terms of the Policy.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance and Premium Rates.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 2] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.
Neither the [Tier 1] nor the [Tier 2] 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 [Carrier] pays is based on all the terms of this Policy.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays 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 [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before [Carrier] pays benefits for [Tier 1] and [Tier 2] Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays 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] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] 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 [Carrier] pays is based on all the terms of this Policy.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a covered person to be in benefit for further Tier 1 covered charges and is also applied toward the satisfaction of the Tier 2 deductible.)

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a [Calendar] [Plan] Year, [Carrier] pays 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] [Plan] Year. What [Carrier] pays is based on all the terms of the Policy.]

[Family Deductible Limit
The 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] [Plan] Year. Once [two] Covered Persons in a family meet [their individual] [two times the] Cash Deductible for treatment, services or supplies given by a Network Provider, [Carrier] pays 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] [Plan] 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] [Plan] Year. Once [two] Covered Persons in a family meet [their individual] [two times the] Cash Deductible for treatment, services or supplies given by a Non-Network Provider, [Carrier] pays 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] [Plan] Year.
What [Carrier] pays is based on all the terms of the Policy.]

[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each [Calendar] [Plan] Year.

Tier 1 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 1 individual deductible limit amount in a [Calendar] [Plan] Year. Once this Tier 1 Family Deductible is met in a [Calendar] [Plan] Year, We provide coverage for all Tier 1 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the [Calendar] [Plan] Year.

Tier 2 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 and Tier 2 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 2 individual deductible limit amount in a [Calendar] [Plan] Year. Once this Tier 2 Family Deductible is met in a [Calendar] [Plan] Year, We provide coverage for all Tier 1 and Tier 2 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: The above text may be used for plans that feature Tier 1 and Tier 2.]

[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] [Plan] 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 has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the [Calendar] [Plan] 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] [Plan] Year.]
[Note to Carriers: Use this Maximum Out of Pocket text for a pure indemnity plan]

[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] [Plan] 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 covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Once two Covered Persons in a family meet their individual Maximum Out of Pocket, no other 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] [Plan] Year.]]

[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] [Plan] Year. All amounts for services and supplies paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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] [Plan] 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] [Plan] Year.]]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network. Omit the Non-Network text if the plan is an EPO.]

[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] [Plan] Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs]for the remainder of the [Calendar] [Plan] Year.

[Once two Covered Persons in a family meet their individual Maximum Out of Pocket, no other 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] [Plan] Year.]]
[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance and Premium Rates.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 2] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] covered services and supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 1] Network or [Tier 2] Network covered services and supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] covered services and supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Covered Person must have Covered Charges that exceed the per Covered Person Cash Deductible before [Carrier] pays any benefits to the Covered Person 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 the Covered Person while insured can be used to meet the Cash Deductible.

Once the per Covered Person Deductible is met, [Carrier] pays benefits for other Covered Charges above the Deductible amount incurred by the Covered Person, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy including benefit limitations and exclusion provisions.

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, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.

[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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Person Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Covered Person, the per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments 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][Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] 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 HSA.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. See the Schedule for these limits.

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

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

If This Plan Replaces Another Plan
The Policyholder who purchased the Policy may have purchased it to replace a plan the Policyholder had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Policyholder's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which the Policy starts or during the 90 days preceding the effective date, whichever is the greater period;
b) the Policy would have paid benefits for the charges if the Policy had been in effect:
c) the Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and
d) the Policy takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.

The Covered Person may have satisfied part of the eligibility Waiting Period under the Policyholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Policy's eligibility Waiting Period if:
a) the Employee was employed by the Policyholder on the date the Policyholder's old plan ended: and
b) the Policy takes effect immediately upon termination of the prior plan.

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

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

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

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's insurance under the Policy ends; or
c) the date the person has reached the payment limit for his or her disabling condition.

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

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

Hospital Charges
[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, [Carrier] covers 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 the Policy, [Carrier] also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

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

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment[, subject to the 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. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay the Copayment shown in the Schedule, 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 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 Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. [Carrier] also provides 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
[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

Extended Care or Rehabilitation Charges
[Subject to [Carrier's] Pre-Approval][Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

[[Carrier] 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 [Carrier] provided that benefits would otherwise be payable under the Policy.]

Home Health Care Charges
[Subject to [Carrier's] Pre-Approval,][W][w]hen home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under the 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. [Carrier] does 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.
Benefits for Home health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

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

Practitioner's Charges for Non-Surgical Care and Treatment
[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does 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.

[Carrier] covers 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. [Carrier] also covers treatment of the physical complications of mastectomy, including lymphedemas.

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 [Carrier] authorizes coverage for such multi-stage procedure. In addition, [Carrier] 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.

Second Opinion Charges
[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
[Carrier] covers charges made by a dialysis center for covered dialysis services.

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

Hospice Care Charges
[Subject to [Carrier] Pre-Approval,][Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.
"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

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

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

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.
[Carrier] does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

[[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies for Hospice Care which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]

Mental Illness or Substance Abuse
[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Mental Illness or Substance Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
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;
d) a Mental Health Canter; or
e) a Substance Abuse Center..

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

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

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

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

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

Anesthetics and Other Services and Supplies
[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches [Carrier] covers 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, [Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
[Carrier] covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

[[Carrier] 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 the [Carrier's] 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 [Carrier's] network clinical laboratory.

[Carrier] will pay the Hospital's clinical laboratory for the laboratory services at the same rate [Carrier] would pay a Network clinical laboratory for comparable services.]

Ambulance Charges
[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
[Subject to [Carrier's] Pre-Approval,][Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option,[and with [Carrier's] Pre-Approval,] [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:
a) 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.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

[[Carrier] will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

Treatment of Wilm's Tumor
[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of the Policy.

Nutritional Counseling
[Subject to [Carrier] Pre-Approval,][Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

[[Carrier] will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]

Food and Food Products for Inherited Metabolic Diseases
[Carrier] 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
[Carrier] covers specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under the [Policy] for Prescription Drugs. [Carrier] covers 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.
[Carrier] may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Policy's Preventive Care section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[[Subject to [Carrier] Pre-Approval, for certain Prescription Drugs]][Carrier] covers drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American 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 [Carrier] pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.
And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[[Carrier] has identified certain Prescription Drugs [including Specialty Pharmaceuticals] for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. [Carrier] will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.]

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact [Carrier] to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact [Carrier] to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. [Carrier] will review the Pre-Approval request within the time period allowed by law. If [Carrier] gives Pre-Approval, [Carrier] 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 the Policy. If [Carrier] does 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 the Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in the Policy.] (Note to Carriers: For use if the plan is a **managed care plan**)

[If a Covered Person brings a prescription for a Prescription Drug for which [Carrier] requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact [Carrier] to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after [Carrier] makes 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 the Policy. If [Carrier] does not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in the Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

[If a Covered Person purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, [Carrier] will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Covered Person is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the Provider states "Dispense as Written" on the prescription the Covered Person will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Covered Person] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Policy pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Covered Person is insured. What [Carrier] pay[s] is subject to all the terms of the Policy.]

[A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. [Carrier] will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Covered Person's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the[Covered Person.

[Carrier] shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Covered Person may follow the Appeals Procedure set forth in the Policy. In addition, the Covered Person may appeal a denial to the Independent Health Care Appeals Program.]

The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Policy.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill [which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

[[Carrier] will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by [Carrier.]]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[[Carrier] will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Covered Person for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Covered Person prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

Supplies to Administer Prescription Drugs

[Carrier] covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

Orally Administered Anti-Cancer Prescription Drugs
As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Policy.

[[Carrier] covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs. [Carrier] covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Covered Person is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.]

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The Covered Person must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the Covered Person may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Policy. Upon receipt of such a claim [Carrier] will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Policy would have provided if the Covered Person had received intravenously administered or injected anti cancer medications [from the Network or Non-Network Practitioner, as applicable] to determine which is more favorable to the Covered Person in terms of copayment, deductible and/or coinsurance. If the Policy provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment deductible and coinsurance is more favorable to the Covered Person. If a Covered Person paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti cancer medications the Covered Person will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
[Carrier] covers 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. [Carrier] 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.

[Carrier] does 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 the Policy for treatments that are not Experimental or Investigational.]

Clinical Trial
The coverage described in this provision applies to Covered Persons who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. [Carrier] provides coverage for the clinical trial if the Covered Person's practitioner is participating in the clinical trial and has concluded that the Covered Person's participation would be appropriate; or the Covered Person provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
[Carrier] provides coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

[Carrier] will not deny a qualified Covered Person participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. [Carrier] will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. [Carrier] will not discriminate against the Covered Person on the basis of the Covered Person's participation in the clinical trial.

Dental Care and Treatment
This Dental Care and Treatment provision applies to all Covered Persons.
[Carrier] covers:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury 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 does [Carrier] cover orthodontic treatment.

[Dental Benefits

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, [Carrier] covers the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19 when services are provided by a [Network] provider.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c) Tests and Examinations

d) Viral culture

e) Collection and preparation of saliva sample for laboratory diagnostic testing

f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*

b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

c) Fluoride varnish once every 3 months for children under the age of 6

d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
   1. Gingivectomy and gingivoplasty
   2. Gingival flap including root planning
   3. Apically positioned flap
   4. Clinical crown lengthening
   5. Osseous surgery
   6. Bone replacement graft – first site and additional sites
   7. Biologic materials to aid soft and osseous tissue regeneration
   8. Guided tissue regeneration
   9. Surgical revision
   10. Pedicle and free soft tissue graft
   11. Subepithelial connective tissue graft
   12. Distal or proximal wedge
   13. Soft tissue allograft
   14. Combined connective tissue and double pedicle graft
b) Non-Surgical Periodontal Service
   1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
   2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
   3. Full mouth debridement to enable comprehensive evaluation
   4. Localized delivery of antimicrobial agents
c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
   1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
   2. Flexible base denture including any clasps, rests and teeth
   3. Removable unilateral partial dentures or dentures without clasps are not considered
c) Overdenture – complete and partial
d) Denture adjustments –6 months after insertion or repair
e) Denture repairs – includes adjustments for first 6 months following service
f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
h) Precision attachment, by report
i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   2. Obturator prosthesis: surgical, definitive and modifications
   3. Mandibular resection prosthesis with and without guide flange
   4. Feeding aid
   5. Surgical stents
   6. Radiation carrier
   7. Fluoride gel carrier
   8. Commissure splint
   9. Surgical splint
   10. Topical medicament carrier

11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
1. Extraction of coronal remnants – deciduous tooth,
2. Extraction, erupted tooth or exposed root
3. Surgical removal of erupted tooth or residual root
4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

c) Other surgical Procedures
1. Oroantral fistula
2. Primary closure of sinus perforation and sinus repairs
3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
4. Surgical access of an unerupted tooth
5. Mobilization of erupted or malpositioned tooth to aid eruption
6. Placement of device to aid eruption
7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
8. Surgical repositioning of tooth/teeth
9. Transseptal fiberotomy/supra crestal fiberotomy
10. Surgical placement of anchorage device with or without flap
11. Harvesting bone for use in graft(s)

d) Alveoloplasty in conjunction or not in conjunction with extractions

e) Vestibuloplasty

f) Excision of benign and malignant tumors/lesions

g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

h) Destruction of lesions by electrosurgery

i) Removal of lateral exostosis, torus palatinus or torus madibularis

j) Surgical reduction of osseous tuberosity

k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

l) Surgical Incision
1. Incision and drainage of abcess - intraoral and extraoral
2. Removal of foreign body
3. Partial ostectomy/sequestrectomy
4. Maxillary sinusotomy

m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
2. Manipulation under anesthesia
3. Condylectomy, discectomy, synovectomy
4. Joint reconstruction
5. Services associated with TMJD treatment require prior authorization

o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

p) Arthroscopy

q) Occlusal orthotic device – includes placement and removal to same provider

r) Surgical and other repairs

1. Repair of traumatic wounds – small and complicated
2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time

6. Nitrous oxide/analgesia
7. Non-intravenous conscious sedation – to include oral medications

c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
- One unit equals 15 minutes of additional time
- Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
  - Office or Clinic maximum – 2 units
  - Inpatient/Outpatient hospital – 4 units
  - Skilled Nursing/Long Term Care – 2 units

d) Consultation by specialist or non-primary care provider

e) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
  - For cases that are treated in a facility.
  - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
  - General anesthesia and outpatient facility charges for dental services are covered
  - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - Single administration
  - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit

h) Occlusal guard – for treatment of bruxism, clenching or grinding

i) Athletic mouthguard covered once per year

j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty

l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as explained in the Explanation of Brackets. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]

For a Covered Person who is severely disabled or who is a Child under age 6, [Carrier] covers:

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.

c)

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, with respect to coverage of TMJ [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of the Policy, and the following limitations:

[Carrier] will cover charges for:

a) one baseline mammogram for a female Covered Person– **who is 40 years of** age

b) one mammogram, every year, for a female Covered Person age 40 and older; **and**

c) a mammogram at the ages and intervals the female Covered Person's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Covered Person who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram [Carrier] will cover charges for:

a) an ultrasound evaluation;

b) a magnetic resonance imaging scan;

c) a three-dimensional mammography; and

d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions are satisfied.

a) The mammogram demonstrates extremely dense breast tissue;

b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or

c) If the female Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, 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.] *[Note to Carriers; Include if policy includes limited non-network benefits.]*

Colorectal Cancer Screening Charges
[Carrier] covers 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, [Carrier] will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

[Carrier] 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.] [Note to Carriers; Include if policy includes limited non-network benefits.]

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

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

Subject to the stated limits, [Carrier] covers the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient [Carrier] covers 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.

[[Subject to [Carrier] Pre-Approval,]][Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
g. *Speech Therapy* -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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per [Calendar] [Plan] Year.

[[Carrier] 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 [Carrier] provided that benefits would otherwise be payable under the Policy.]

j.*Infusion Therapy* – [subject to [Carrier] Pre-Approval,]the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **[[Carrier] will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the 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 to services provided while a Covered Person is confined in a Facility or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
[Carrier] provides coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability [Carrier] provides coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are and subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
c) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Covered Person's primary diagnosis is autism, in addition to coverage for the therapy services as described above, [Carrier] also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. [Carrier] may request additional information if necessary to determine the coverage under the Policy. [Carrier] may require the submission of an updated treatment plan once every six months unless [Carrier] and the treating physician agree to more frequent updates.

If a Covered Person:
a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a Covered Charge under this Policy. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

Fertility Services
[Subject to [Carrier] Pre-Approval][Carrier] covers charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in the Policy. [Carrier] covers charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of the Policy.

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

[But [Carrier] limits what [Carrier] pays each [Calendar] [Plan] Year to:
a) $750 per Covered Person for a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1,
b) $500 per Covered Person for all other Covered Persons.

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $750 and $500 limits to not apply to services from a Network Practitioner.]
[Note to Carriers: Include only for policies that provide non-network benefits if the carrier chooses to apply the limits to non-network benefits.]

Immunizations and Lead Screening
[Carrier] 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.

Hearing Aids
[Carrier] covers charges for medically necessary services incurred in the purchase of a hearing aid for a Covered Person age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

Newborn Hearing Screening
[Carrier] covers 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, [Carrier] covers charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Vision Screening
[Carrier] covers 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.
Vision Benefit
Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, [Carrier] covers the vision benefits described in this provision for Covered Persons through the end of the month in which he or she turns age 19. [Carrier] covers one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. [Carrier] covers one pair of lenses, for glasses or contact lenses, in a 12 month period. [Carrier] covers one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

[Carrier] covers charges for a one comprehensive low vision evaluation every 5 years. [Carrier] covers low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Transplant Benefits
[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia

- Genetic Disorders
- SCID
- WISCOT Aldrich

[Subject to [Carrier] Pre-Approval,] [B][b]reast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **[[Carrier] will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]**

- j) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

k)Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, the Policy will cover the donor's medical costs associated with the donation. [Carrier] does not cover costs for travel, accommodations or comfort items.

IMPORTANT NOTICE

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

a) is admitted as an Inpatient to a Hospital, or

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

[The Policy has 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.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

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

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

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, Specialty Case Management or Centers of Excellence Features.]

[UTILIZATION REVIEW FEATURES

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

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

a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Policy.

Definitions

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

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

"Regular working day" means [Monday through Friday from 9 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. 11:24A-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 the Policy.

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

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.
[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency 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. [[Carrier] reduces what it pays for covered Hospital charges, **by 50%**] if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

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

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

Penalties cannot be used to meet the Policy's Maximum Out of Pocket or Cash Deductible.

[REQUIRED PRE-SURGICAL REVIEW

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

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

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

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].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or 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, [[Carrier] reduces what it pays for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's Maximum Out of Pocket or Cash Deductible.

[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 [Carrier] 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 the Policy for the Covered Person's condition, the services and supplies the [Carrier] offers to make available under the terms of this provision would not otherwise be payable under the Policy.

Please note: [Carrier] has 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) Substance Abuse
l) Mental Illness
m) any other Illness or Injury determined by [DEF] or [Carrier] 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) [Carrier].

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 [Carrier], [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 the 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] [Plan] Year maximums.

Exclusion
Specialty Case Management does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

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

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

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

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

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

EXCLUSIONS

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

*[**Abortion**, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]*
Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.
The amount of any charge which is greater than an ***Allowed Charge***.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

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

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

Completion of claim forms.

*[**Preventive contraceptive services and supplies** that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]*

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in the 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 the Policy.

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

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

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

Extraction of teeth, except for bony impacted teeth or as otherwise covered under the Policy.

Services or supplies for or in connection with:
a) except as otherwise stated in the Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens or as otherwise covered under the Policy; 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 the Employee's ***family:*** spouse, child, parent, in- law, brother, sister or grandparent.
Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

Except as stated in the Hearing Aids and 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. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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 the Policy.

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

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

Non-prescription drugs or supplies, except
a) insulin needles and syringes and glucose test strips and lancets;
b) colostomy bags, belts and irrigators; and
c) as stated in the 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.

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

Services related to ***Private Duty Nursing care,*** except as provided under the Private Duty Nursing section of the Policy.

Benefits may be based on a contractual fee schedule [The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed
g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
h) Charges for a Prescription Drug which is to be taken by or given to the [Covered Person], in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home or similar institution
- a provider' office.

i) Charges for:
- therapeutic devices or appliances

- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

m) Charges for any drug used in connection with baldness.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by a [Covered Person] taking part in a riot or other civil disorder; or the

o)[Covered Person] taking part in the commission of a felony.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

q) Charges for drugs dispensed to a [Covered Person] while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by the [Covered Person's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] [is/are] legally required to pay it, [Carrier] will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the [Policy.]

t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.

u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Covered Persons with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

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 the 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) 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 the Policy and under military health coverage and who receive care in facilities of the Uniformed Services.

e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or

[Subject to [Carrier] Pre-Approval,] [E][e]ligibility 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 [Carrier] are Non-Covered Charges.]

Stand-by services required by a Provider.

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

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.
[Telephone consultations. [except as stated in the Practitioner's Charges for Non-Surgical Care and Treatment provision].]]

Transplants, except as otherwise listed in the Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war***, or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.

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 surgery section of this Policy and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A Covered Person who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

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

If a Covered Person elects to continue his or her group health benefits under this Policy's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

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

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

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

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

a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:

a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:

a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:

a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends

A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice

Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:

a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:

a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees

If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to [the Carrier] within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Policyholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.
The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Policy [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by the Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or if the domestic partnership terminates], the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN
HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP
Date Group Health Benefits Insurance Ends
Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of the Policy will not apply to him or her and his or her Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 30 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY
Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

Request made because:
a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in]the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Covered Person] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Policy] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows [Carrier] to coordinate what [Carrier] pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Policy] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.

When this [Policy] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, [Carrier] will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: An amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Covered Person] is covered by this [Policy] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Covered Person] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Covered Person's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:
a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Covered Person] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Covered Person] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

[Carrier] considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Covered Person] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Covered Person] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Covered Person] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Covered Person] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:
a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.
d)If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 Allowed Charge (AC), 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 an Allowed Charge is called an "AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Covered Person] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that then HMO or EPO 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 and "EPO" refers to Exclusive Provider Organization.

Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPO 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.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) the Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.
If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.
If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if the Policy had been primary.

Medicare
If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary
When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a Covered Person who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].;; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age;
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease ; or
c) A Covered Person who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].
d) .

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".
This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

STATEMENT OF ERISA RIGHTS
The following Statement may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

[CLAIMS PROCEDURE
Carriers should include claims procedures consistent with the requirements of ERISA.]
[Carriers may include additional information consistent with the requirements of 29 C.F.R. 2590.715 – 2715.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
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.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Administrative correction.
See: 44 N.J.R. 2184(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT X

(RESERVED)

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Repealed 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).

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Repealed by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

EXHIBIT Y

[Carrier]
HMO PLAN
SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
EVIDENCE OF COVERAGE
[Plan Name]

[[Carrier] certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.]

[The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.]

CONTRACTHOLDER: [ABC Company]
GROUP CONTRACT NUMBER: [G-12345]
[EMPLOYEE: [John Doe]]
[CERTIFICATE NUMBER: [C-123456]]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE: [January 1, 2016]

[COVERED CLASSES:
[All Employees of the Contractholder (and its Associated Companies) who permanently live, work or reside in the Service Area and are eligible or covered under the Group Care Health Plan.]]

SERVICE AREA: [The State of New Jersey]
AFFILIATED COMPANIES: [DEF Company]
COST OF THE COVERAGE:
[The coverage in this Evidence of Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll.]

[HMO's Address: [400 Main Street
Chester, New Jersey 00000]

This Evidence of Coverage replaces any older Evidence of Coverage issued to You for the Group Health Care Plan.

[Secretary President]

[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]

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SCHEDULE OF SERVICES AND SUPPLIES [Using Copayment]

THE SERVICES OR SUPPLIES COVERED UNDER THE CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER [CALENDAR] [PLAN] YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES **COPAYMENTS[/COINSURANCE]:**

HOSPITAL SERVICES:

INPATIENT	[$100 to $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [dollar amount equal to 10 times the per day copayment]/[Calendar] [Plan] Year. Unlimited days.
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	[at the option of the carrier, $50, $75 or $100] Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours)

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

URGENT CARE	[amount consistent with N.J.A.C. 11:22-5.5(a)]
SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit
HOME HEALTH CARE	60 Visits, if Pre-Approved; amount consistent with N.J.A.C. 11:22-5.5(a)Copayment per [day] [visit].
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	$0 Copayment
THERAPEUTIC MANIPULATION	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit; maximum 30 visits/[Calendar] [Plan] Year
PRE-ADMISSION TESTING	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with Copayments consistent with N.J.A.C. 11:22-5.5(a)]
PRIMARY CARE PROVIDER	
For services other than Preventive Care	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
[SERVICES (OUTSIDE HOSPITAL)	
[TELEMEDICINE VISITS	[dollar amount not to exceed $50]]
[E-VISITS	[dollar amount not to exceed $50]]
[VIRTUAL VISITS	[dollar amount not to exceed $50]]
PREVENTIVE CARE	$0 copayment
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	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
SPECIALIST SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
SKILLED NURSING FACILITY/EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; amount consistent with N.J.A.C. 11:22-5.5(a)Copayment.
THERAPY SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit.
Speech and Cognitive Therapy (Combined), maximum30 visits per [Calendar] [Plan] Year See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	

Physical and Occupational Therapy (Combined) maximum 30 visits per [Calendar] [Plan] Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits
[COMPLEX IMAGING SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]]
[ALL OTHER] DIAGNOSTIC SERVICES **INPATIENT** **(OUTPATIENT)** [amount consistent with N.J.A.C. 11:22-5.5(a)]]Copayment/visit	. $0 Copayment
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] [Plan] Year per [Member], unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT	
For Preventive Care	NONE
For all other Primary Care Provider Visits	[[amount consistent with N.J.A.C. 11:22-5.5(a)]]] per visit
Maternity (pre-natal care)	NONE
For Prescription Drugs	[Copayments consistent with N.J.A.C. 11:22-5.5]
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER [CALENDAR] [PLAN] YEAR	
•For Primary Care Provider Visits including Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•Second Surgical Opinion	NONE
•for all other Covered Services and Supplies	
•Per Covered Person	Dollar amount not to exceed deductible permitted by 45 CFR 156.130(b)]]
• [Per Covered Family	[Dollar amount which is two times the individual Deductible.] **Note:** Must be individually satisfied by 2 separate Members
COINSURANCE	
For Preventive Care	0%
Prescription Drugs	50%
[Vision Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other services and supplies to which a Copayment does not apply	[10% - 50%, in 5% increments]
For all services and supplies to which a Copayment applies	None

EMERGENCY ROOM COPAYMENT [amount consistent with N.J.A.C. 11:22-5.5]
Copayment/visit/Member (credited toward Inpatient admission if admission occurs within 24 hours as the result of the emergency).
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

[URGENT CARE [amount consistent with N.J.A.C. 11:22-5.5(a)]]
MAXIMUM OUT OF POCKET
Maximum Out of Pocket means the annual maximum dollar amount that a Member Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a [Calendar] [Plan] 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 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] [Plan] Year.

The **Maximum Out of Pocket** for the Contract is as follows:

- •Per Member per [Calendar] [Plan] Year [An amount not to exceed $6,850 or amount permitted by 45 C.F.R. 156.130]
- [Per Family per [Calendar] [Plan] Year [Dollar amount equal to two times the per Member Maximum.]

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

SCHEDULE OF SERVICES AND SUPPLIES
Example HMO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges.)

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

SERVICES	[Tier 1]	[Tier 2]]
[Calendar] [Plan] Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Pre-natal visits	NONE	NONE
Prescription Drugs		[$250]
[Generic Drugs]		[$50]
[Preferred Drugs]		[$100]
[Non-Preferred Drugs]		[$150]
[All other Covered Services and Supplies		
Per Member	$1,000	$1,500
Per Covered Family	$2,000	$3,000]
(Use above deductible for separate accumulation..)		
[All other Covered Services and Supplies		
Per Member	$1,000	$2,500
Per Covered Family	$2,000	$5,000
(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)		
Copayment applies after the Cash Deductible is satisfied		
Preventive Care	NONE	NONE
Primary Care Provider Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30

SERVICES	[Tier 1]	[Tier 2]]
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Pre-natal visits	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]	N/A See Tier 2	50% [10%] [20%] [50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Member	$2,000	$4,400
Per Covered Family	$4,000	$8,800]
(Use above for separate accumulation.)		
[Maximum Out of Pocket Per [Calendar] [Plan] Year (See definition below) Per Member	$2,000	$6,850 or amount permitted by 45 C.F.R. 156.130
Per Covered Family	$4,000	$12,700]
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		

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

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] [Plan] 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 Member 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] [Plan] Year.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care 60 visits per [Calendar] [Plan] Year, subject to Pre-Approval.

Hospice Services	Unlimited days, subject to Pre-Approval.
Speech and Cognitive Therapy (Combined) See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per [Calendar] [Plan] Year
Physical and Occupational Therapy (Combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per [Calendar] [Plan] Year
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits per [Calendar] [Plan] Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits per [Calendar] [Plan] Year
Therapeutic Manipulation	30 visits per [Calendar] [Plan] 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 [FOR CARE THROUGH HIS OR HER PRIMARY CARE PROVIDER . READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THE 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 THE CONTRACT.]

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies 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.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

ALLOWED CHARGE. Means an amount that is not more than the [lesser of:
• the] allowance 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 an Allowed Charge under this Contract.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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 the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

[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.]

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

It must:
a)carry out its stated purpose under all relevant state and local laws; or
b)be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c)be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Benefits Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

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.]

[COMPLEX IMAGING SERVICES. Any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and [Carrier].

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments.*

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 EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract.

Read the entire Contract to find out what We limit or exclude.

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 Covered Person 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) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1996 (COBRA), Pub. L. 99-272, as subsequently amended; and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

Your " Dependent child" includes Your legally adopted child, Your step-child, Your foster child, the child of his or her civil union partner, [and] [,the child of his or her domestic partner, and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

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 sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We 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 as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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

EFFECTIVE DATE. The date on which coverage begins under the Contract for the Contractholder, or the date coverage begins under the Contract for a [Member], as the context in which the term is used suggests.

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.

[EMPLOYEE. A Full-Time bona-fide Employee (25 hours per week) of the Contractholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Contract. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[EMPLOYEE. An Employee of the Contractholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

EMPLOYEE OPEN ENROLLMENT PERIOD. The 30-day period each year designated by the Contractholder during which:
a) Employees and Dependents who are eligible under the Contract but who are Late Enrollees may enroll for coverage under the Contract; and
b) Employees and Dependents who are covered under Contract may elect coverage under a different policy, if any, offered by the Contractholder.

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment;
b) [the day] after any applicable waiting period ends; or
c) [the day] after any applicable Orientation Period ends.

EMPLOYER. [ABC Company].

EMPLOYER OPEN ENROLLMENT PERIOD. The period from November 15 through December 15 each year beginning in 2014.

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the [Member's] Enrollment Date does not change.

[E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and [Members] who are established patients of the Provider.]

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.

FULL-TIME. A normal work week of [25] [30] or more hours. Work must be at the Contractholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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 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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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 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 the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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. Illness includes Mental Illness.

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

INJURY 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.

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

[LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[MAIL ORDER PROGRAM. A program under which a [Member] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

[MAINTENANCE DRUG. Only a Prescription Drug used for the treatment of chronic medical conditions.]

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

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

In the instance of 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 the Contract (includes Covered Employee[and covered Dependents, if any)].

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. The Employee will have access to up-to date lists of [Network] Providers.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in the Contract.

NON- [NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

[NON-PREFERRED DRUG. A drug that has not been designated as a Preferred Drug.]

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.

[ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

OUTPATIENT. [Member], if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and not an Inpatient; or services and supplies provided in such Outpatient settings.

[PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[PARTICIPATING PHARMACY. A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

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.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. § 1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

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. For more information regarding the services for which We require Pre-Approval, consult the website at [www.xxx.com]]

[PREFERRED DRUG. A Prescription Drug that; a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Members, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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. As used in this Contract preventive care means:
a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

PRIMARY CARE PROVIDER (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.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

[REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Provider in conformance with our policies and procedures that direct 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."

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, 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.

[SMALL EMPLOYER. Means:

a) In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar] Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year; OR

b) in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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)].

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:

a) Late Enrollees are permitted to enroll under the Contractholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Contractholder.

[SPECIALTY PHARMACETICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care;
d) any of the procedures designated by the Current Procedural Terminology Codes as surgery.

[TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].

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.

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

TRIGGERING EVENT. The following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.
d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

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

[VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the [Member] and the Provider.]

[WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

[WE, US, OUR. [Carrier].]

[YOU, YOUR, YOURS. An Employee who is covered under the Contract.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees[who are in an eligible class and] who reside in the Service Area will be eligible if the Employees are [Actively at Work] Full-Time Employees[.][In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,] We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under the Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under the Contract and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Contract, We will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee must enroll under the Contract within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under the Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
The Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under the Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under the Contract. But, if the Contract uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or number of work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and] working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, We will postpone the start of his or her coverage until he or she returns to Active Work.]

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

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

If the Employee does this more than [30] days after the Employee's Eligibility Date, We will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement

The Exception applies if the Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:

a) the Employee was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Contract.]

Exception: If the coverage under the Contract is richer than the coverage under the Contractholder's old plan, the Contract will provide coverage for services and supplies related to the disabling condition. The Contract will coordinate with the Contractholder's old plan, with the Contract providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends

An Employee's coverage under the Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under the Contract.
c) the date the Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) [the date] for which required payments are not made for the Employee, subject to the **Payment of Premiums - Grace Period** section.
e) [the date] an Employee no longer lives, works or resides in the Service Area.]

[DEPENDENT COVERAGE

Contractholder Election

A Contractholder that elects to make Dependent coverage available under the Contract may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Contractholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Contract is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits

[Except as stated below, Your] [Your] eligible Dependents are:

a) Your legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended); and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.
b) Your Dependent children who are under age 26.

[Exception: Any dependent who does not reside in the Service Area is not an eligible Dependent.]

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

Adopted Children, Step-Children, Foster Children

Your " Dependent children" include Your legally adopted children, Your step-children, Your foster children, the child of his or her civil union partner, [and] [, the child of his or her domestic partner, and] children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

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

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

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

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

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

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Contract. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under the Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under the Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in the Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the employer's contribution toward coverage that was made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under the Contract, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.
Coverage will take effect as of the date required pursuant to the court order.

In addition, if an Employee initially waived coverage under the Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under the Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for an Employee's dependent coverage to begin the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Contract, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents[and agrees to make any required payments].

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

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

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:

a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

The coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Contract.

Newborn Children
We will cover an Employee's 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:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under the Contract.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

1) give written notice to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth.]

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, the child will be a Late Enrollee.

When Dependent Coverage Ends:
A Dependent's coverage under the Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date the Contract ends;
[d)]. the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. at 12:01 a.m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Dependent spouse, the date the spouse moves his or her permanent residence outside the Service Area.]

EXTENDED HEALTH BENEFITS
If the Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Contract:
a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the[Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any identification card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes material information that is either incorrect or incomplete in a statement made for the purpose of effecting coverage under the Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.

d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [Network Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the [Member] such written notice:

a) that person will cease to be a [Member] for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeal Procedures We establish.

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider 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 Provider] 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 Provider and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Provider .

[Members] select a Primary Care Provider 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 Provider initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Provider selection. [If a [Member] fails to select a Primary Care Provider , We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Provider, [Members] can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Provider 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.

[NETWORK
The Member will have access to given up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]]

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to the Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under the Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under the Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under the Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of the Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to the Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES
In the event that due to circumstances not within Our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Our [Network] Providers or entities with whom We have arranged for services under the Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under the Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

[REFERRAL FORMS
A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Provider.

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 Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.]
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 the 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 the Contract. In such event, We will continue to provide all benefits covered by the 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 the Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS
We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, the Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition 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 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 Provider or a Provider referred in writing by the Primary Care Provider without notifying the [Member] that such benefit would not be covered under the 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 **Providers** 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. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[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 the 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 the Contract, whichever occurs first.

We shall not continue services in those instance 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 the 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 Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

The Cash Deductible
Each [Calendar] [Plan] 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] [Plan] Year. But all charges must be incurred while that Member is covered by the Contract. What We cover is based on all the terms of the Contract.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of the Contract.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)

[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] [Plan] 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 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] [Plan] Year.]

[Once two Members in a family meet their individual 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] [Plan] Year.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network or [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable [copayment or] Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any [copayment or] Coinsurance, for the rest of that [Calendar] [Plan] Year.

Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member

Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]
[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.
The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which the Contract starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Contract would have provided coverage for the charges if the Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

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 [or Coinsurance] as stated in the applicable Schedule of Services and Supplies and subject to the terms, conditions and limitations of the 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 Provider's office selected by a [Member], [or elsewhere upon prior written Referral by a [Member]'s Primary Care Provider]:
1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
2. **Home visits** by a [Member]'s Primary Care Provider.
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 Provider and Pre-Approved by Us.
7. **Procedures and Prescription Drugs to enhance fertility,** except where specifically excluded in the Contract. [Subject to Pre-Approval] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of the Contract.
8.
Orthotic or Prosthetic Appliances We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network.

Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.

9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **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. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]

[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] Network Provider.

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

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[We have identified certain Prescription Drugs for which Pre-Approval is required [such as Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee 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 the 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 the Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in the 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.

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]
[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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 Provider 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) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;

g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months . Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

21). Orally Administered Anti-Cancer Prescription Drugs As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

[We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the [Member] is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs.

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The [Member] must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the [Member] may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Contract would have provided if the [Member] had received intravenously administered or injected anti cancer medications from the Network to determine which is more favorable to the [Member] in terms of copayment, deductible and/or coinsurance. If the Contract provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment deductible and coinsurance is more favorable to the [Member]. If a [Member] paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti cancer medications the [Member] will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

22) **Vision Benefit** Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

23) **Mammogram Coverage**
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of the Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office 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 Provider].

(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 Provider,] 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 the 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 childbirth and newborn 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.

We also cover 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.

20. The following transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestines.
21. Allogeneic bone marrow transplants.

[22. 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.]

[22 or23.] 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;

[23 or 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.]

[24. Or 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 MENTAL ILLNESS OR SUBSTANCE ABUSE. We cover treatment of Mental Illness or Substance Abuse the same way We would for any other illness, if such treatment is prescribed by a Network Provider upon prior written [by a [Member]'s Primary Care Provider]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:

a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered [without prior written Referral by a [Member]'s Primary Care Provider] in the event of an Emergency as Determined by Us.

1. A [Member]'s Primary Care Provider 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 Provider [or Us] prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area [without a prior written Referral] only if:

a. Our review Determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
c. We and the [Member]'s Primary Care Provider 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 [or the [Member] shall be responsible for payment.]

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.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Network Provider [upon prior written Referral by a [Member]'s Primary Care Provider]. 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.

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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..

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 Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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 or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

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(g) DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES

We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:

a) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;

b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and

c) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.

Member Person:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and

b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a Covered Service under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

(h) **HOME HEALTH CARE.** The following Services are covered [upon prior written referral from a [Member]'s Primary Care Provider]. 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.

Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

(i)**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 Provider. 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.

(j) **DENTAL CARE AND TREATMENT.**

Dental benefits available to all [Members]

The following services are covered for all [Members] when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Provider]. 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.

[Dental Benefits available to [Members] through the end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

- Dental services are available from birth with an age one dental visit encouraged.

- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused
b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap

4. Clinical crown lengthening
5. Osseous surgery
6. Bone replacement graft – first site and additional sites
7. Biologic materials to aid soft and osseous tissue regeneration
8. Guided tissue regeneration
9. Surgical revision
10. Pedicle and free soft tissue graft
11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b) Non-Surgical Periodontal Service
1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.

1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects

9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units

d) Consultation by specialist or non-primary care provider
e) Professional visits
   - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   - Hospital or ambulatory surgical center call
     - o For cases that are treated in a facility.
     - o For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
     - o General anesthesia and outpatient facility charges for dental services are covered
     - o Dental services rendered in these settings by a dentist not on staff are considered separately
   - Office visit for observation – (during regular hours) no other service performed
f) Drugs
   - Therapeutic parenteral drug
     - o Single administration
     - o Two or more administrations - not to be combined with single administration
   - Other drugs and/or medicaments – by report
g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
   - Limited - (per visit)
   - Complete (regardless of the number of visits), once in a lifetime
k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted if a stand-alone dental plan is bought. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]
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 the Contract which requires Hospitalization or general anesthesia.

(k) **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 Provider]. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Provider]. We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

(m) [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, with 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 the Contract for treatments that are not Experimental or Investigational.]

(o) CLINICAL TRIAL The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THE CONTRACT.

[Abortion, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]

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

The amount of any charge which is greater than an **Allowed Charge**.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless[Member] is being transferred to another Inpatient health care Facility.
[Broken Appointments.]

Blood or blood plasma which is replaced by or for a[Member].

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

Completion of claim forms.

[Preventive contraceptive services and supplies that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]
Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in the 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 the Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in the Contract.

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

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.

Extraction of teeth, except for bony impacted teeth or as otherwise covered under the Contract.

Services or supplies for or in connection with:
a) except as otherwise stated in the Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens or as otherwise covered under the Contract; 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 the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), donor sperm, surrogate motherhood; and b) Prescription Drugs not eligible under the Prescription Drugs section of the Contract ; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal..

Except as otherwise stated in the Hearing Aids and Newborn Hearing Screening provisions, 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. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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.**
Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in the 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.

[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.

b) Charges for:

- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.

e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed

g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home or similar institution
- a provider' office.

i) Charges for:

- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

m) Charges for any drug used in connection with baldness.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the

o)Member taking part in the commission of a felony.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

q) Charges for drugs dispensed to a Member while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract

t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.

u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.
[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

[Any service provided without prior written Referral by the [Member]'s **Primary Care Provider,** except as specified in the Contract.]

Services related to **Private Duty Nursing**, except as provided under the Private Duty Nursing section of the Contract.

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) 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 the Contract and under military health coverage and who receive care in facilities of the Uniformed Services.

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. [except as stated in the Outpatient Services provision].]

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**, or an act of war, if the Illness or Injury occurs while the Member is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area.

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 surgery section of the Contract and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Contract] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Us to coordinate what We pay or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Contract] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.

When this [Contract] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: 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 .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Member] is covered by this [Contract] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Member] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Member's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or

b) All Plans which cover the [Member] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Member] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period, the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Member] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Member] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Member] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Member] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.

b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.

c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.

d)If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.

b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.

c) The benefits of the Plan of the parent without custody shall be determined last.

d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 Allowed Charge (AC), 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 an Allowed Charge is called an "AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Member] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that the HMO, EPO 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 and "EPO" refers to Exclusive Provider Organization.

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Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPO 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 the 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) the Contract;
b) PIP; or
c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under the Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under the Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

If there is a dispute as to which policy is primary, the Contract will pay benefits or provide services as if it were primary.

Services the Contract will provide if it is primary to PIP or OSAIC.
If the Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:
a) the[Member] is insured or covered for services under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.
If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

GENERAL PROVISIONS

CLERICAL ERROR - MISSTATEMENTS

Except as stated below, neither clerical error nor programming or systems error by the Contractholder, nor Us in keeping any records pertaining to coverage under the Contract, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Contractholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision of the Contract, such return of premium will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

RETROACTIVE TERMINATION OF A [MEMBER'S] COVERAGE

We will not retroactively terminate a [Member's] coverage under the Contract after coverage under the Contract take effect unless the [Member] performs an act, practice, or omission that constitutes fraud, or unless the [Member] makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation We will provide at least 30 days advance written notice to each [Member] whose coverage will be retroactively terminated.

If a Contractholder continues to pay the full premium for a [Member] who is no longer eligible to be covered the Contractholder may request a refund of premium as explained in the Premium Refunds provision of the Contract. If We refund premium to the Contractholder the refund will result in the retroactive termination of the [Member's] coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

CONFORMITY WITH LAW

Any provision of the 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 the Contract.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under the Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS

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

OTHER RIGHTS

We are only required to provide benefits to the extent stated in the Contract, its riders and attachments. We have no other liability.

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 the Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Contractholder's application may not be used by Us to void the Contract or in any legal action unless the application or a duplicate of it is attached to the Contract or has been furnished to the Contractholder for attachment to the Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under the Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at [Our] [XYZ's] office [or to one of our authorized agents.] A premium payment is due on each premium due date stated on the first page of this Contract. The Contractholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Contractholder is liable to pay premiums for the time this Contract is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for contracts issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Contract will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for contracts issued inside the SHOP]*

WORKERS' COMPENSATION
The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A [Member] who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

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

If a [Member] elects to continue his or her group health benefits under this Contract's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice
Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:
a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.
If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:
a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Contract ends;
f) the end of the period for which the last premium payment is made;

g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union, [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to Us within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].
Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Contract [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under the Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under the Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Contract.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.
When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under the Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of the Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS
If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or termination of the domestic partnership], the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **Exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage. or
c) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under the Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.
If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and the Contract will be the secondary health plan for [Members] who are eligible for Medicare. Benefits will be payable as specified in the COORDINATION OF BENEFITS AND SERVICES section of the Contract.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **COORDINATION OF BENEFITS AND SERVICES** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When the Contract is primary
When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, the Contract is the primary plan. The Contract is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if a ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract.

[STATEMENT OF ERISA RIGHTS
The following Statement may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.
[Carriers may include additional information consistent with the requirements of 29 C.F.R. 2590.715 – 2715.]

New Rule, R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
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).
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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Repeal and New Rule, R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT AA

(RESERVED)

New Rule, R.1994 d.97, 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).
Repealed by R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(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 #:_____
Respondent Information:
Name: _____ Title: _____
Address: _____
_____
Telephone:_____ FAX:_____ Email address: _____

2. COMPLIANCE

Check the appropriate response(s).

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

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

_____(d) The HMO/POS plan (both contract and evidence of coverage) complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibits HH, JJ and K, respectively, 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 B through E , HMO and HMO-POS 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 Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(g) All applications, certifications, and waiver forms, comply fully with the SEH Board's forms and the explanation of Brackets as set forth in Exhibits N, O, T, and K, respectively, of the Appendix to N.J.A.C. 11:21.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section. Attach additional pages as necessary.

(a) Plans A through E

On the attached worksheet for Plans A through E, provide information regarding all of the plans carrier makes available using Plans A through E. 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. 11:21-3.1 for information regarding permissible options.

Delivery System: Identify whether each plan is sold as Traditional Indemnity (Designate as Indem), Preferred Provider Organization (Designate as PPO); or Point of Service (Designate as POS).

Copayment: For all plans that use a copayment, specify the applicable copayments for Physician Visits, Maternity and Emergency Room. Note: All plans, regardless of delivery system, must specify the level of Emergency Room Copayment.

Deductible: List the available deductible options as specific amounts, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common deductible should list that amount under the Indemnity/Common column. PPO and POS plans that use separate deductibles for network and non-network services should list such amounts under the appropriate column headings. Under Family Deductible/network indicate if the family deductible is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate deductible, specify the family deductible under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

Coinsurance: List the available coinsurance options as specific percentages, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common coinsurance should list that amount under the Indemnity/Common column. PPO and POS plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.

Maximum Out of Pocket ("MOOP"): List the available maximum out of pocket as specific amounts, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common maximum out of pocket should list that amount under the Indemnity/Common column. PPO and POS plans that use a separate maximum out of pocket for network and non-network services should list such amounts under the appropriate column headings. . Under Family MOOP/network indicate if the family maximum out of pocket is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate MOOP, specify the family MOOP under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

1. Do contracts provide for direct payment to health care practitioners without assignment? Yes No
2. Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A-24 and N.J.A.C. 11:21-7.6)

Yes No

If No, has the Board approved the carrier's use of an alternate participation requirements? Yes No

3. Do the plans include any of the following as set as variable text in the standard plans?

Yes	No	
		Utilization Review Features
		Required Hospital Stay Review
		Required Pre-surgical Review
		Specialty Case Management
		Centers of Excellence Features
		Appeal Procedures
		Active Work requirement for non-health status related factors
		Pre-existing conditions exclusion

4. Specify how coverage for autologous bone marrow transplants is offered.

Plan A selection: Plan benefit: or Rider benefit

Plans B through E selection: Plan benefit: or Rider benefit

5. Are the plans available through a multiple employer trust (MET)? Yes No If yes, complete the following:
Name and address of trustee:

Name of Settlor: _____ Contract State: _____

6. Are Plans C or D being offered as the non-network coverage of a Dual Contract HMO/POS Plan? Yes No

7. Is the standard prescription drug rider (Exhibit H) being made available? Yes No If yes, complete the Prescription Drug Rider section of this Certification with respect to each variation of the rider.

(b) HMO and HMO-POS Plans

On the attached worksheet for HMO Plans, provide information regarding all of the plans carrier makes available using the HMO and HMO-POS plans. 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. 11:21-3.1 for information regarding permissible options.

Plan Type: Specify all options carrier makes available for the HMO plan as well as all options, if any, the carrier makes available for the HMO-POS plan.

Copayment: Specify the applicable copayments for Physician Visits, Maternity and Emergency Room.

Deductible: List the available deductible options as specific amounts, not as a ranges. POS plans that use a common deductible should list that amount under the Common column. POS plans that use separate deductibles for network and non-network services should list such amounts under the appropriate column headings. Under Family Deductible/network indicate if the family deductible is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate deductible, specify the family deductible under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

Coinsurance: List the available coinsurance options as specific percentages, not as a ranges. POS plans that use a common coinsurance should list that amount under the Common column. POS plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.

Maximum Out of Pocket: List the available maximum out of pocket as specific amounts, not as a ranges. POS plans that use a common maximum out of pocket should list that amount under the Common column. POS plans that use a separate maximum out of pocket for network and non-network services should list such amounts under the appropriate column headings. . Under Family MOOP/network indicate if the family maximum out of pocket is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate MOOP, specify the family MOOP under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

Prescription Drugs: For HMO plans indicate whether prescription drugs are covered subject to 50% coinsurance or a $15 copayment. (Designate as 50% or 15)

1. Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A-24 and N.J.A.C. 11:21-7.6)

Yes No

If No, has the Board approved the carrier's use of an alternate participation requirements? Yes No

2. Do the plans include any of the following as set as variable text in the standard plans?
Yes No

Active Work requirement for non-health status related factors

Pre-existing conditions exclusion

3. Specify how coverage for autologous bone marrow transplants is offered

HMO selection: Plan benefit; or Rider benefit

HMO-POS selection: Plan benefit; or Rider benefit

4. Is the HMO plan being used as network coverage of a Dual Contract HMO/POS Plan? Yes No

5. Is the standard prescription drug rider (Exhibit II) being made available with plans? Yes No If yes, complete the Prescription Drug Rider section of this Certification with respect to each variation of the rider.

(c) **Prescription Drug Rider**

Mail/Retail	Retail Only	Mail Only
_____	Generic Copayment	
_____	Brand Copayment	
_____	Preferred Brand Copayment	
_____	Non-Preferred Brand Copayment	

Is pre-approval required? Yes No
Available with plans : _____

Mail/Retail	Retail Only	Mail Only
_____	Generic Copayment	
_____	Brand Copayment	
_____	Preferred Brand Copayment	
_____	Non-Preferred Brand Copayment	

Is pre-approval required? Yes No
Available with plans : _____

Mail/Retail	Retail Only	Mail Only
_____	Generic Copayment	
_____	Brand Copayment	
_____	Preferred Brand Copayment	
_____	Non-Preferred Brand Copayment	

Is pre-approval required? Yes No
Available with plans : _____

Mail/Retail	Retail Only	Mail Only
_____	Generic Copayment	
_____	Brand Copayment	
_____	Preferred Brand Copayment	
_____	Non-Preferred Brand Copayment	

Is pre-approval required? Yes No
Available with plans : _____

Note: Exhibit BB Part 6, which addresses the availability of optional benefit riders, must be completed by all carriers, whether or not optional benefit riders have been filed.

4. CERTIFICATION

I, the Undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

I certify that any stop loss or excess risk insurance issued or renewed by the carrier meets the retention limits set forth in the definition of "stop loss" or "excess risk insurance" as defined at N.J.S.A. 17B:27A-17.

_____ _____ _____
Signature Title

_____ _____ _____
Printed Name Date

Carrier Name: _____

Plans A through E

Plan	Delivery System	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP	
		Physician Visit	Maternity	Emergency Room	Indemnity or Common	Network	Non-Network	Network	Non-Network	Indemnity	Network	Non-Network	Indemnity or Common	Network	Non-Network	Network	Non-Network
A																	
B																	
C																	
D																	
E																	

EXAMPLES

Plan	Delivery System	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP	
		Physician Visit	Maternity	Emergency Room	Indemnity or Common	Network	Non-Network	Network	Non-Network	Indemnity	Network	Non-Network	Indemnity or Common	Network	Non-Network	Network	Non-Network
C	indem			50	1000, 2500			2X indiv	2X indiv	70%			5000			2X indiv	2X indiv
C	PPO	15, 30	15, 30	50		1000, 250	2000, 5000	2X indiv	2X indiv		70%	100%		5000	10000	2X indiv	2X indiv
D	POS	30,50	30,50	50		1000, 250	2000, 5000	2X indiv	2X indiv		80%	100%		5000	15000	2X indiv	2Xindiv

Carrier Name _____

HMO and HMO-POS Plans

Plan Type	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP		Pescription
	Physician Visit	Maternity	Emergency Room	HMO or Common	Network	Non-Network	Network	Non-Network	HMO	Network	Non-Network	HMO or Common	Network	Non-Network	Network	Non-Network	
HMO																	
HMO-POS																	

EXAMPLES

Plan Type	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP		Pescription
	Physician Visit	Maternity	Emergency Room	HMO or Common	Network	Non-Network	Network	Non-Network	HMO	Network	Non-Network	HMO or Common	Network	Non-Network	Network	Non-Network	
HMO	15,20,30	15,20,30	75														50%
	30		75	2500			2X indiv		80%			5000			2X indiv		50%
HMO-POS	20,30	20,30	75	2500			2X indiv	2X indiv		100%	80%	5000			2X indiv	2X indiv	
	15, 20	15, 20	75		2500	5000	2X indiv	2X indiv		100%	70%		5000	15000	2Xindiv	2X indiv	

EXHIBIT BB

PART 2

CERTIFICATION OF PROMOTIONAL
AND MARKETING MATERIAL

Submit this form pursuant to N.J.A.C. 11:21-17.3 by March 1 of every year to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and to the Division of Life and Health Actuaries, New Jersey Department of Banking and Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625-0325, Attn: SEH Promotional and Marketing Certification.

Carrier's Name: _____ NAIC #: _____

Respondent's Name: _____

Respondent's Title _____

Respondent's Address: _____

_____

Respondent's Phone: _____ FAX: _____

Respondent's Email: _____

I, the undersigned, hereby certify that the promotional and marketing material to be disseminated regarding the small employer health benefits plans, including all terms definitions and text, are consistent with N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21.

I certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

_____ _____

Date Signature (No stamps)

Printed Name

_____

Title

PARTS 3 THROUGH 5

(RESERVED)

EXHIBIT BB

PART 6

USE OF
OPTIONAL BENEFIT RIDERS

In accordance with N.J.A.C. 11:21-3, 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.

A. 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 Phone: _____ FAX: _____

Respondent's Email: _____

B. OPTIONAL BENEFIT RIDERS

1. Optional Benefit Riders of Increasing Value (N.J.A.C. 11:21-3.2)

Have you filed any optional benefit riders of increasing value that have been found to be complete and in substantial compliance by the SEH Board?

_____ Yes _____ No

If yes, please provide the following information for each optional benefit rider that has been filed with the SEH Board where the filing was determined to be complete and in substantial compliance with the requirements of N.J.A.C. 11:21-3.2. Attach additional sheets, as may be necessary. If no, skip to part B2.

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available: _____

d) If rider is no longer available, explain why:
_____
_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:
_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:
_____
_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:
_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:

which this nonstandard health benefits plan is sold or marketed?
____ Yes ____ No ____ NA
If no, does the carrier market and sell the nonstandard health benefits plan through:
Agent force: ____ Yes ____ No
Direct sale: ____ Yes ____ No

h. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):
January: _____ July: _____
February: _____ August: _____
March: _____ September: _____
April: _____ October: _____
May: _____ November: _____
June: _____ December: _____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, and rules and promulgated thereunder, specifically N.J.A.C. 11:21-3A.

4. CERTIFICATION
I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefit plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____
Date Signature

_____
Title

PART 4
CERTIFICATION OF INFORMATIONAL FILING AND COMPLIANCE WITH P.L. 1994, C.11

In accordance with N.J.A.C. 11:21-11.8(b), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN-325, Trenton, NJ 08625-0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT
Carrier's Name: _____
NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
_____
Respondent's Phone: _____ FAX: _____

2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION
(Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)
a. Form identification number: _____
b. Form's market name: _____
c. Specify the reason(s) why this nonstandard health benefits plan was not submitted to the Department for filing prior to April 4, 1994:
_____
_____
_____
____ Check here if additional pages are attached.
d. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No
If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:
_____
_____

____ Check here if additional pages are attached.

e. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?
____ Yes ____ No ____ NA
If yes, specify the final date that policies, contracts or certificates will be issued under this nonstandard health benefits plan: ____

f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by which this nonstandard health benefits plan is sold and marketed?
____ Yes ____ No ____ NA
If no, does the carrier market and sell the nonstandard health benefits plan through:
Agent force: ____ Yes ____ No
Direct sale: ____ Yes ____ No

g. Specify the number of policies, contracts or certificates in force under this form by anniversary date (by month):

January: _____	July: _____
February: _____	August: _____
March: _____	September: _____
April: _____	October: _____
May: _____	November: _____
June: _____	December: _____

3. Attach the amendments made to the nonstandard health benefits plan that are necessary to comply with the provisions of N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, and rules promulgated thereunder.

4. CERTIFICATION
I, the undersigned, certify that this completed form, including additional pages attached hereto and incorporated herein, is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.
I certify that, in accordance with P.L.1994, c. 11, policies, contracts or certificates issued or renewed under this nonstandard health benefits plan have been and shall be brought into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L.1994, c. 11, on their respective first anniversary dates occurring after September 11, 1994, and further, that in no instance shall any policies, contracts or certificates issued or renewed under this nonstandard health benefits plan fail to be in compliance as specified at P.L.1994, c. 11 any later than September 11, 1995.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate shall be issued or renewed under this nonstandard health benefits plan through or by any association, multiple employer arrangement or out-of-state trust after February 28, 1996.
I certify that, in accordance with N.J.A.C. 11:21-3A, no policy, contract or certificate reinstated, continued or renewed under this nonstandard health benefits plan by (Carrier's name) shall be renewed after February 28, 1996.

_____ _____
Date Signature

_____
Title

PART 5
STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
CHECKLIST AND CERTIFICATION
NONSTANDARD SMALL EMPLOYER HEALTH BENEFIT PLANS AND/OR AMENDMENTS FILED PURSUANT TO N.J.S.A. 17B:27A-19J(6)(b), (6)(c), (11) and (12)

CARRIER: _____
NAIC NO. (If Applicable): _____
IDENTIFYING FORM NUMBERS (List all forms to which this checklist and certification applies and identify for each form whether it is open or closed):
TYPES OF FORMS SUBMITTED:
_____ POLICY/CONTRACT
_____ POLICY/CONTRACT INSERT PAGES/BENEFIT RIDER
_____ CERTIFICATE/EVIDENCE OF COVERAGE
_____ CERTIFICATE/EVIDENCE OF COVERAGE INSERT PAGES/BENEFIT RIDER
_____ GROUP APPLICATION
_____ EMPLOYEE ENROLLMENT FORM (APPLICATION)

Note: When submitting insert pages or a benefit rider for use with a policy or certificate, the Checklist and Certification should be completed considering the policy or certificate with the insert pages or benefit rider attached. When multiple policy and/or certificate insert pages or policy and/or certificate benefit riders are included in the same submission, to the extent that the insert pages/benefit riders can simultaneously be attached to the policy or certificate, only one Checklist and Certification need be completed for the combination.

1. Do you certify that the form(s) does not include provisions, statements, or questions that pertain to race, creed, color, national origin, ancestry or sexual orientation?
____ Yes ____ No

2. Is the form(s) in a final printed format?
_____ Yes _____ No

3. Does the form(s) contain a unique identifying number in the lower left-hand corner of the first page?
_____ Yes _____ No

4. Do you certify that the form(s) does not contain any provision or benefit previously disapproved by this Department?
_____ Yes _____ No
If "No", please identify the provision or benefit and when such was disapproved by the Department.
_____
_____

5. Does the form(s) satisfy all of the readability requirements specified in N.J.S.A. 17B:17-21a?
_____ Yes _____ No

6. Do you certify that the form(s) comply with each of the following? If "No" for any response, identify the form number.
   a. N.J.S.A. 17B:27A-18 (applicability of act, availability of coverage)
   _____ Yes _____ No Form # _____
   b. N.J.S.A. 17B:27A-19(b) (guarantee issue)
   _____ Yes _____ No Form # _____
   c. N.J.S.A. 17B:27A-22 (preexisting condition)
   _____ Yes _____ No Form # _____
   d. N.J.S.A. 17B:27A-23 (renewal)
   _____ Yes _____ No Form # _____
   e. N.J.S.A. 17B:27A-24 (participation and contribution requirements)
   _____ Yes _____ No Form # _____
   f. N.J.S.A. 17B:27A-25 (rating)
   _____ Yes _____ No Form # _____
   g. N.J.S.A. 17B:27A-27 (continuation of coverage)
   _____ Yes _____ No Form # _____

7. If a group application, does the form contain the exact statement regarding fraud contained in Section 6c of P.L. 1995, c.132?
_____ Yes _____ No

8. Does the form(s) comply with:
   a. N.J.A.C. 11:4-42.5(a) Domestic Violence?
   _____ Yes _____ No
   b. N.J.A.C. 11:2-13 Group Coverage Discontinuance and Replacement?
   _____ Yes _____ No
   c. N.J.A.C. 11:4-28 Group Coordination of Benefits?
   _____ Yes _____ No

9. Does the plan contain definitions of the following terms at least as favorable to consumers as those contained in Plan A for the following? See appendix to N.J.A.C. 11:21 for text of Plan A.

a.	Ambulatory Surgical Center	_____ Yes	_____ No
b.	Birthing Center	_____ Yes	_____ No
c.	Dependent	_____ Yes	_____ No
d.	Employee	_____ Yes	_____ No
e.	Extended Care Center	_____ Yes	_____ No
f.	Full-Time	_____ Yes	_____ No
g.	Hospice	_____ Yes	_____ No
h.	Hospital	_____ Yes	_____ No
i.	Nurse	_____ Yes	_____ No
j.	Practitioner (or similar term)	_____ Yes	_____ No
k.	Reasonable and Customary (not applicable to HMO Plans)	_____ Yes	_____ No
l.	Rehabilitation Center	_____ Yes	_____ No
m.	Special Care Unit	_____ Yes	_____ No
n.	Total Disability or Totally Disabled?	_____ Yes	_____ No

10. Does the plan contain provisions at least as favorable to consumers as the following provisions contained in Plan A?

a.	Incontestability	_____ Yes	_____ No
b.	Payment of Premiums—Grace Period	_____ Yes	_____ No
c.	Participation Requirements	_____ Yes	_____ No

d. Termination of the Policy— Renewal Privilege _____ Yes _____ No

11. Does the plan cover at least each of the following charges/services which are covered by Plan A?

a. Charges while hospitalized, 30 days/calendar year (room, board) and ancillary charges.
_____ Yes _____ No

b. Testing—X-Ray and laboratory prior to hospital admission.
_____ Yes _____ No

c. At least 60 days of extended care or rehabilitation (in lieu of hospital confinement, 2 for 1 exchange with hospital days).
_____ Yes _____ No

d. At least 60 days of home health care (2 for 1 exchange with hospital days).
_____ Yes _____ No

e. At least 60 days of hospice care (2 for 1 exchange with hospital days).
_____ Yes _____ No

f. Practitioner charges, nonsurgical while hospitalized
_____ Yes _____ No

Surgical _____ Yes _____ No

Anesthesia _____ Yes _____ No

g. Second Opinion _____ Yes _____ No

h. Ambulatory Surgery _____ Yes _____ No

i. Pregnancy coverage on same basis as sickness (No dollar or day limits) _____ Yes _____ No

j. Birthing Center _____ Yes _____ No

k. Newborn Child Coverage _____ Yes _____ No

l. Therapy:

Chemotherapy (inpatient and outpatient) _____ Yes _____ No

Radiation (inpatient and outpatient) _____ Yes _____ No

Chelation (inpatient) _____ Yes _____ No

Respiration (inpatient) _____ Yes _____ No

Cognitive rehabilitation and speech (inpatient, aggregate of at least 30/year) _____ Yes _____ No

Occupational and speech (inpatient, aggregate of at least 30/year) _____ Yes _____ No

Infusion (inpatient) _____ Yes _____ No

m. Fertility (inpatient, artificial insemination and standard doses, length of treatment and cycles of FDA approved drugs)
_____ Yes _____ No

n. Preventive ($100/person, $300/family)
_____ Yes _____ No

o. Autologous bone marrow transplant (c.100, P.L. 1995)
_____ Yes _____ No

p. Insulin needles, syringes, glucose test strips, lancets
_____ Yes _____ No

q. Colostomy bags, belts, irrigators _____ Yes _____ No

r. Prescriptions (inpatient) _____ Yes _____ No

I, the undersigned, certify that:

1. I am familiar with this form submission and all of the New Jersey insurance laws, regulations and bulletins applicable to this type of form;
2. The form and the submission comply with all of the New Jersey insurance laws, regulations and bulletins applicable to this type of form;
3. The carrier intends for the New Jersey Department of Insurance to rely on this certification in accepting this submission;
4. I am aware of the penalties for submitting an improper certification or false submission;

_____
Signature of Responsible Officer

_____
Name of Responsible Officer (Print)

_____
Title of Responsible Officer

_____
Date

CERTIFICATION OF ACTUARIAL FORM

As a member of the American Academy of Actuaries, I certify that I am familiar with both the standard health benefit plans established by the Small Employer Health Benefits Program Board (SEH Board) and the nonstandard plans identified on the first page of this checklist and certification, and I am qualified to provide an opinion concerning the actuarial value of such nonstandard plans.

The actuarial value of the nonstandard plans identified on the first page of this checklist and certification is at least as great as the actuarial value of the lowest standard health benefits plan established by the SEH Board, considering all variables associated with the nonstandard plans.

_____ _____

Date Signature of Actuary
(Must be MAAA)

EXHIBIT BB

PART 6

USE OF
OPTIONAL BENEFIT RIDERS

In accordance with N.J.A.C. 11:21-3, 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.

A. 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 Phone: _____ FAX: _____

Respondent's Email: _____

B. OPTIONAL BENEFIT RIDERS

1. Optional Benefit Riders of Increasing Value (N.J.A.C. 11:21-3.2)

Have you filed any optional benefit riders of increasing value that have been found to be complete and in substantial compliance by the SEH Board?

_____ Yes _____ No

If yes, please provide the following information for each optional benefit rider that has been filed with the SEH Board where the filing was determined to be complete and in substantial compliance with the requirements of N.J.A.C. 11:21-3.2. Attach additional sheets, as may be necessary. If no, skip to part B2.

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available: _____

d) If rider is no longer available, explain why:
_____
_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:
_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:
_____
_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:
_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:

c) Date the SEH Board found the rider to be complete and in substantial compliance:

2. **Optional Benefit Riders of Decreasing Value**

Have you filed any optional benefit riders of decreasing value that have been approved by the Department of Banking and Insurance?

_____ Yes _____ No

If yes, please provide the following information for each optional benefit rider that has been filed with the Department of Banking and Insurance where the filing was approved. Attach additional sheets, as may be necessary. If no, skip to section C.

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:

b) Brief Description of the nature of the amendment:

c) Plan(s) with which the rider is available:

d) If rider is no longer available, explain why:

e) Date the Department of Banking and Insurance approved the rider

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:

b) Brief Description of the nature of the amendment:

c) Plan(s) with which the rider is available:

d) If rider is no longer available, explain why:

e) Date the Department of Banking and Insurance approved the rider

C. **CERTIFICATION**

I certify that the optional benefit riders identified above are the only riders to the standard health benefit plans issued by the carrier identified above which are not the standard riders adopted by the SEH Board.

I, the Undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

Date

Signature (No stamps)

Printed Name

Title

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Administrative correction.
See: 30 N.J.R. 1047(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.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

EXHIBIT CC

New Jersey Small Employer Health Benefits Program
Carrier Small Employer Market Share Report

This report must be completed in accordance with the provisions of N.J.A.C. 11:21-10, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier. Reports must be completed and returned on or before April 15, 1994 and by **March 1** of each year thereafter. Completed Reports must be returned to SEH Program Administrator as set forth in N.J.A.C. 11:21-1.3.

Part A. Carrier Information

1. Carrier's Name: _____

2. Carrier's NAIC Number: _____

3. Is the above named Carrier as affiliated Carrier?
   _____Yes ____No

   a. If Yes, please list all Carriers with whom the above named Carrier is affiliated. List only those affiliates that had group health benefits plans in force for small employers in the preceding calendar year.

Name	NAIC#

Part B. Personal Respondent Information

1. Name: _____

2. Title: _____

3. Mailing Address: _____

   _____

4. Telephone No. _____ FAX No. _____

Part C. Calendar Year Information for 199
Net earned premium for all small employer group health benefits plans: $ _____

Part D. Certification
I certify that information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:21-10.

_____ _____ _____
Signature **Title** **Date**

New Rule, R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).
Administrative correction.
See: 30 N.J.R. 1047(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.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

Exhibit DD

[Carrier]

AMENDMENT

[Policyholder]

Group [Policy] No.

Effective Date:

This Amendment is part of the [Policy].

Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].

[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1995 d.312, effective June 19, 1995.
See: 27 N.J.R. 439(a). 27 N.J.R. 2407(b).
Administrative correction.
See: 30 N.J.R. 1047(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

EXHIBIT EE

(RESERVED)

EXHIBIT FF

(RESERVED)

New Rule, R.1995 d.289, effective June 5, 1995.
See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).
Administrative correction.
See: 30 N.J.R. 1047(a).
Repeal and New Rule, R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Section was "SEH Program Premium Comparison Survey".
Repeal and New Rule, R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
Exhibit was "SEH Program Premium Comparison Survey".
In accordance with N.J.S.A. 52:14B-5.1b, Appendix Exhibit FF, SEH Program Premium Comparison Survey, expired on August 18, 2016.
See: 43 N.J.R. 1203(a).

EXHIBIT GG

Loss Ratio Report Form
New Jersey Small Employer Health Benefits Program
Reporting Year _____
For Preceding Calendar Year Ending December 31, _____
Name of Carrier: _____ NAIC # _____
Address: _____
Check one: Insurance Company _____ HMO _____ Service Plan _____

A separate Report Form shall be completed and filed for each affiliate in addition to a combined report form for affiliated insurance companies or affiliated HMOs. Definitions and instructions regarding words and terms appearing below may be found on the reverse side.

	Total	Standard Plans	Open Non-Standard Plans	Closed Non-Standard Plans	Purchasing Alliance Plans
1. Premiums					
2. Claims (a. + b.–c. + d.–e.)					
(See definitions, reverse side)					
a.					
b.					
c.					
d.					
e.					
3. Loss ratio (2./1.)					
4. Dividends (.80 x 1.–2.)*					
5. Dividend Percentage (4.+1.)					

* Note Instruction 4.

I certify that the above information is accurate and complete and has been prepared in accordance with N.J.A.C. 11:21–7A. If dividends (or credits) are required, an explanation of our plan to issue them is attached.

Actuary's Signature	Date	Type or Print Actuary's Name
Title		Telephone Number

REPORTING FORM DEFINITIONS AND INSTRUCTIONS

1. "Premiums" are the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before dividends or credits applicable to prior years: (a) combined for all Standard Health Benefits Plans; (b) combined for open Nonstandard Health Benefits Plans; and (c) combined for Closed Nonstandard Health Benefits Plans. Include all Rider Premiums, both Standard and Nonstandard Riders, with the respective Plans which are ridered. The Closed Nonstandard Plans column is for the policies which are renewal only policies continued pursuant to N.J.S.A. 17B:27A-19j(3)(b).

2. "Claims" are equal to:

a. claims paid in the preceding calendar year regardless of the year incurred;

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

c. less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding year's Loss Ratio Report);

d. plus a residual reserve equal to 3.3 percent of a. + b.-c.;

e. less the residual reserve as reported in the preceding calendar year's Loss Ratio Report.

3. "Loss Ratio" is the quotient, to the nearest .1 percent, of the Claims divided by the Premiums (2. divided by 1.).

4. "Dividends" are calculated on a combined basis for all standard health benefits plans; for all open nonstandard health benefits plans combined; and for all Closed Nonstandard health benefits plans combined. "Dividends" are equal to 80 percent of the Premiums less Claims (80% of 1. less 2.). (No dividends are required to be paid for nonstandard plans for reporting year 1995.) If the calculated amount is less than zero, then use zero. The Total column should be the sum of the calculated plan columns.

5. "Dividend Percentage" is the percentage ratio of Dividends to Premiums (4. divided by 1.).

Loss Ratio Reports are required to be completed and filed with the Department on or before August 1 of each year for the preceding calendar year, in accordance with N.J.A.C. 11:21-7A. Reports and all required accompanying statements and other information should be sent to the Department at the following address:

Attn: SEH Loss Ratio Report Filings
Life and Health Division
NJ Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).
Administrative correction.
See: 30 N.J.R. 1047(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the exhibit.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added a new column "Purchasing Alliance Plans".
Amended by R.2009 d.277, effective September 21, 2009.
See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).
Substituted "80" for "75" throughout the exhibit.

EXHIBIT HH

[Carrier] **HMO - POS PLAN**
[Plan Name]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)
POINT OF SERVICE (POS) CONTRACT

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER **GOVERNING JURISDICTION**
[G-12345] NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [January 1, 2016]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 2017.]

PREMIUM DUE DATES: [Effective Date, and the 1st day of the month beginning with February 2016.]

AFFILIATED COMPANIES: [DEF Company]

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies and pay benefits in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

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

[Secretary President]

[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]]

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SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are set forth on the [rate quote] for this Contract for the effective date shown on the face page of the Contract.

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.**

This Contract's classifications, and the coverages and amounts which apply to each class are shown below:

CLASS(ES)
[All eligible employees]

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)
[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Hospital		
Inpatient (unlimited days)	[$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30 Copayment / visit	Deductible/Coinsurance]
Pre-natal care	[$0] Copayment / visit	Deductible/Coinsurance
Practitioner Services	[$15] Copayment / visit	Deductible/Coinsurance
[Telemedicine Visits	[$15] Copayment / visit	N/A]
[E-Visits	[$15] Copayment / visit	N/A]
[Virtual Visits	[$15] Copayment / visit	N/A]
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$0] Copayment / visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
[Complex Imaging Services	[$30 Copayment]	Deductible/Coinsurance]
[All other] Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	Deductible/Coinsurance	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Home Health Care	Covered; [$30] Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using separate deductible/coinsurance and maximum out of pocket for network and non-network services)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-Natal Care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
[Urgent Care	[$30] Copayment / visit	Deductible/Coinsurance]

SERVICES	[NETWORK]	[NON-NETWORK]
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network	
Per Member	[not to exceed deductible permitted by 45 CFR 156.130(b)]]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]
Non-Network	
Per Member	[Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]
Coinsurance	
Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

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

Per member per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member maximum.]

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 Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member 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] [Plan] Year.

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member Maximum.]

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

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using common deductible and maximum out of pocket for network and non-network services but separate coinsurance)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-natal care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30] Copayment/visit	Deductible/Coinsurance]
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network and Non-Network	
Per Member	[amount not to exceed deductible permitted by 45 CFR 156.130(b)]]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Coinsurance	
Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member maximum.]

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

LIMITATIONS ON SERVICES AND SUPLIES

:Unless otherwise stated, the following limitations represent the maximum number of days or visits for use of any combination of Network and Non-Network Providers.

Charges for Home Health Care	60 Visits
Charges for therapeutic manipulation per [Calendar] [Plan] Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits

Charges for physical or occupational therapy per [Calendar] [Plan] Year (combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note:** The 30-visit limit does not apply to the treatment of autism.	30 visits

Charges for Preventive Care per [Calendar] [Plan] Year as follows:

Network:	Unlimited
Non-Network: (Not subject to Cash Deductible or Coinsurance)	
[• for a Member who is a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1	$750 per Member]
• for all [other] Members	$500 per Member

Charges for hearing aids for Members age 15 or younger	One hearing aid per hearing impaired ear per 24-month period

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)

Network:	Unlimited
Non-Network:	Unlimited

[NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PROVIDER . READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THIS CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]]

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

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

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

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

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:

a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

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.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

ALLOWED CHARGE. With respect to [Network] services and supplies, the negotiated arrangement.

With respect to [Non-Network] benefits, Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance 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 an Allowed Charge under this Contract. For charges that are not determined by a negotiated fee schedule, the [Member] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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.]

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

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Benefits Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before this Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of this Contract for details.

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 or the percentage of Covered Charges, as applicable, that must be paid by a [Member]. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

[COMPLEX IMAGING SERVICES. Any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Allowed Charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Contract, as applicable to [Non-Network] benefits. The services and supplies must be:
a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

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

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

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 a [Member] meet a [Member's] routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for that part of the care which is mainly custodial.

[DEPENDENT. An Employee's:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended; and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b)Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].
Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

An Employee's " Dependent child" includes his or her legally adopted child, his or her step-child, his or her foster child the child of his or her civil union partner, [and] [, the child of his or her domestic partner, and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a)the Employee's Eligibility Date; or
b)the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under this Contract if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We 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 as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Contractholder, or the date coverage begins under this Contract for a [Member], as the context in which the term is used suggests.

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.

[EMPLOYEE. A Full-Time bona-fide Employee (25 hours per week) of the Contractholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[EMPLOYEE. An Employee of the Contractholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

EMPLOYEE OPEN ENROLLMENT PERIOD. The 30-day period each year designated by the Contractholder during which:
a) Employees and Dependents who are eligible under the Contract but who are Late Enrollees may enroll for coverage under the Contract; and
b) Employees and Dependents who are covered under Contract may elect coverage under a different policy, if any, offered by the Contractholder.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment;
b) [the day] after any applicable waiting period ends; or
c) [the day] after any applicable Orientation Period ends.

EMPLOYER. [ABC Company].

EMPLOYER OPEN ENROLLMENT PERIOD. The period from November 15 through December 15 each year beginning in 2014.

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the [Member's] Enrollment Date does not change.
[E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and [Members] who are established patients of the Provider.]

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:

a) The American Hospital Formulary Service Drug Information; or
b) 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 non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

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

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

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing 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.

FULL-TIME. A normal work week of [25] [30] or more hours. Work must be at the Contractholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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 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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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 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 the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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 disease. Illness includes Mental Illness.

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

INJURY 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 health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

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

[LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[MAIL ORDER PROGRAM. A program under which a [Member] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

[MAINTENANCE DRUG. Only a Prescription Drug used for the treatment of chronic medical conditions.]

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

[MEMBER]. An eligible person who is covered under this Contract (includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. The Employee will have access to up-to date lists of [Network] Providers.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

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

NON-COVERED CHARGES. Charges which do not meet this Contract's definition of Covered Charges or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by this Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in this Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

[NON-PREFERRED DRUG. A drug that has not been designated as a Preferred Drug.]

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.

[ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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.

[PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[PARTICIPATING PHARMACY. A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. § 1002(16)(B)). That is:

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Our approval using paper or electronic means for specified services and supplies prior to the date the 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 by payable under the Contract. For more information regarding the services for which We require Pre-Approval, consult the website at [www.xxx.com]]

[PREFERRED DRUG. A Prescription Drug that; a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Members, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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. As used in this Contract preventive care means:
a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

PRIMARY CARE PROVIDER (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Members who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.
REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Provider in conformance with Our policies and procedures that direct 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."

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, and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of 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.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

[SMALL EMPLOYER. Means:

a) In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year; OR

b) In connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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

c) neonatal care units; and
d) burn units.

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Contractholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Contractholder.

[SPECIALTY PHARMACETICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a)be accredited for its stated purpose by the Joint Commission; or
b)be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

[TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].

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.

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

TRIGGERING EVENT. The following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.
d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

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

[VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the [Member] and the Provider.]

[WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

[WE, US, OUR. [Carrier].]
YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] [and] [who live, work or reside in the Service Area] will be eligible if the Employees are [Actively at Work] Full-Time Employees. [In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,]We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment;

We will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Contract and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee must enroll under this Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs..

If an Employee initially waived coverage under this Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under this Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under this Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]
If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
This Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under this Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under this Contract. But, if this Contract uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and] working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, We will postpone the start of his or her coverage until he or she returns to Active Work.]

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

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

If the Employee does this more than [30] days after the Employee's Eligibility Date, We will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:

a) the Employee was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.]

Exception: If the coverage under this Contract is richer than the coverage under the Contractholder's old plan, this Contract will provide coverage for services and supplies related to the disabling condition. This Contract will coordinate with the Contractholder's old plan, with this Contract providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends

An Employee's coverage under this Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Contract.
c) the date this Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) the last day of the period for which required payments have been made for the Employee, subject to the **Payment of Premium - Grace Period** section.
e) [the date] an Employee no longer lives, works or resides in the Service Area.]

[DEPENDENT COVERAGE

Contractholder Election

A Contractholder that elects to make Dependent coverage available under the Contract may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Contractholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Contract is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are:

a) the Employee's legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended); and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b)the Employee's Dependent children who are under age 26.

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children, Step-Children, Foster Children

An Employee's " Dependent children" include the Employee's legally adopted children, his or her step-children, his or her foster children, the child of his or her civil union partner, [and] [,the child of his or her domestic partner, and] children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

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

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

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

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

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. We consider an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

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

In addition, if an Employee initially waived coverage under this Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

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

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

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

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

The coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.

Newborn Children
We will cover an Employee's 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:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee 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.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
1) give written notice to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the 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, the child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's coverage under this Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date this Contract ends;
[d)]. the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. At 12:01 a.m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Dependent spouse, the date the spouse moves his or her permanent residence outside the Service Area.]

EXTENDED HEALTH BENEFITS

If this Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under this Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of this Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other family members.

The extension ends on the earliest of:
a)the date the Total Disability ends;
b)one year from the date the person's coverage under this Contract ends; or
c)the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under this Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes 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, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.

f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider 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 Provider 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 Provider and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Provider.

[Members] select a Primary Care Provider 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 Provider initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Provider selection. [If a [Member] fails to select a Primary Care Provider, We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Provider, [Members] can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Provider 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.

[NETWORK
The Member will have access to given up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]]

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under this Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or

rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

[REFERRAL FORMS
A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Provider.

Except in the case of an Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.]

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 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.

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, Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of 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 may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Provider or a Provider referred in writing by the Primary Care Provider without notifying the [Member] that such benefit would not be covered under this Contract.

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 **Providers** 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. 811:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[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 instance 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.]

COVERED SERVICES AND SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [Cash Deductible,] [or Coinsurance] as stated in the applicable Schedule 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.

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

[COVERAGE PROVISION

[The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

The Cash Deductible
Each [Calendar] [Plan] 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] [Plan] 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 Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Members in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of this Contract.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]
[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)
[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)

[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] [Plan] 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 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] [Plan] Year.]

[Once Members in a family meet two times the individual Maximum Out of Pocket, no Members 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] [Plan] Year.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network or [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.

Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] 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 HSA.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which this Contract starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Contract would have provided coverage for the charges if this Contract had been in effect:

c) the Member was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

Note to carriers: The Coverage Provision section is only to be included in plans where Network coverage is subject to deductible and coinsurance.]

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Provider's office selected by a [Member], or elsewhere [upon prior Referral by a [Member's] Primary Care Provider].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
2) **Home visits** by a [Member's] Primary Care Provider.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine gynecological 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 Provider and Pre-Approved by Us.
7) Procedures and Prescription Drugs to enhance fertility, except where specifically excluded in this Contract. [Subject to Pre-Approval,] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8) Orthotic or Prosthetic Appliances We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network.

Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.

9)Durable Medical Equipment when ordered by a [Member's] Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10)[Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]

[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] [Network] Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]
[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee 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.

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.]

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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 **Provider** 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) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months.. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.
Hearing aids are habilitative devices.

21) **Orally Administered Anti-Cancer Prescription Drugs** As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs do not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Member is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs.

[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Network coverage the Contract provides for intravenously administered or injected anti cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Network copayment, deductible and/or coinsurance for intravenously administered or injected anti cancer medications the Member will be reimbursed for the difference.]
[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

22) **Vision Benefit** Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

23) **Mammogram Coverage**
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours[upon prior Referral by a [Member's] Primary Care Provider].

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** Except as stated below,
the following Services are covered when hospitalized by a [Network] Provider upon prior [from a [Member's] Primary Care Provider], only at [Network] Hospitals and [Network] Facilities (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.
Exception: If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

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 minimum of 48 hours of Inpatient care in a [Network] Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of Inpatient care in a [Network] Hospital following a cesarean section.
• We provide childbirth and newborn coverage subject to the following:
⇒ the attending Practitioner must determine that Inpatient care is medically necessary; or
⇒ the mother must request the Inpatient care.
• [As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing 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 Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services.
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.

We also cover 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.

20.The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
21. Allogeneic bone marrow transplants.
[22. 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.]

[22 or 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;
[23 or 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.]
[24. or 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 MENTAL ILLNESS OR SUBSTANCE ABUSE. We cover treatment of a Mental Illness or Substance 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 Provider]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered [without prior Referral by a [Member's] Primary Care Provider] in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Provider 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 Provider[or Us prior to seeking Emergency treatment.
II. We will cover the cost of services and supplies in connection with an Emergency provided within or outside our service area [without a prior 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 a [Member's] Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for services received unless We Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
III. In the event a [Member] is hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided[upon prior Referral] to a [Network] Provider.

4) Coverage for Emergency services includes only such treatment necessary to treat the Emergency. [Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior 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 Member has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior [by a [Member's] Primary Care Provider]. 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.
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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per [Calendar] [Plan] 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 or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision..

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.

(g) DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
c) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.
Member Person:
a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a Covered Service under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

NOTE: ANY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Provider. 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.

Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

NOTE: ANY HOME HEALTH CARE BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE HOME HEALTH CARE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

i.) 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 Provider. 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.

(j) DENTAL CARE AND TREATMENT.
Dental benefits available to all [Members]

The following services are covered for all [Members] when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care **Provider]**. 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.

[Dental Benefits available to [Members] through the end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.
- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.

- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c) Tests and Examinations

d) Viral culture

e) Collection and preparation of saliva sample for laboratory diagnostic testing

f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*

b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

c) Fluoride varnish once every 3 months for children under the age of 6

d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening
    5. Osseous surgery
    6. Bone replacement graft – first site and additional sites
    7. Biologic materials to aid soft and osseous tissue regeneration
    8. Guided tissue regeneration
    9. Surgical revision
    10. Pedicle and free soft tissue graft

11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b) Non-Surgical Periodontal Service
1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.

5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects
   9. Frenectomy and frenoplasty
   10. Excision of hyperplastic tissue and pericoronal gingiva
   11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
   12. Emergency tracheotomy
   13. Coronoidectomy

14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
    - Hospital or ambulatory surgical center call

- o For cases that are treated in a facility.
- o For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
- o General anesthesia and outpatient facility charges for dental services are covered
- o Dental services rendered in these settings by a dentist not on staff are considered separately

- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - o Single administration
  - o Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted if a stand-alone dental plan is bought. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]
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.

(k) **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 **Provider]**. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l)**THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner[upon prior Referral by a [Member's] Primary Care Provider]. We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

(m) [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, with 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.]

(n) CLINICAL TRIAL The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

[NON-NETWORK] BENEFIT PROVISION *APPLICABLE TO [NON-NETWORK] BENEFITS*

The Cash Deductible
Each [Calendar] [Plan] Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that [Member], less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while that [Member] is covered by this Contract. And what We pay is based on all the terms of this Contract.

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the [Calendar] [Plan] Year in which this Contract starts;
b) the charges would have been considered Covered Charges under this Contract if this Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit
This Contract has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two [Members] in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of this Contract.]

[Per Covered Family

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

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.]

[Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.]

[Note to carriers: Use the above For Single Coverage Only and Other than Single Accumulation, For example, the text would be included if the plan is a high deductible health plan that could be used in conjunction with an HSA]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member 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] [Plan] Year.

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no 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] [Plan] Year.]]

[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 Member must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no 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] [Plan] Year.]]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

COVERED CHARGES ***APPLICABLE TO [NON-NETWORK] BENEFITS***

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of this Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in this Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement. If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

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 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) 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 childbirth and newborn care 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 [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment[, subject to this Contract's **Emergency Room Copayment Requirement** section].

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. This Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

[Emergency Room Copayment Requirement
Each time a [Member] uses the services of a Hospital emergency room, he or she must pay the Copayment shown in the Schedule 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 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. [Carrier] 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 Member has a potentially life-threatening condition. Information on the use of the "911" system is included in 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 cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

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 Contract.

Home Health Care Charges:
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Member 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 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.
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.
We do not pay for:
A. services furnished to family members, other than the patient; or
B. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

ANY HOME HEALTH CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE HOME HEALTH CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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 Contract.

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.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does 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.

[Carrier] covers 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.

We also cover 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.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally Ill" or "terminally Injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

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

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

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

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 Contract.

Mental Illness or Substance Abuse
We pay benefits for the Covered Charges a [Member] incurs for the treatment of Mental Illness or Substance 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.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;

c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

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

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of this Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

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 [Member].

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 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.]

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) 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.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

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 Contract.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Contract.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

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 Contract.

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 the [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.

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 [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
c) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
d) 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 Contract'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] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to the Employee before adding 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.]

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]
[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.]

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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.

Orally Administered Anti-Cancer Prescription Drugs
As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs do not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Member is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.

[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Non-Network coverage the Contract provides for intravenously administered or injected anti cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Non-Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Non-Network copayment, deductible and/or coinsurance for intravenously administered or injected anti cancer medications the Member will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2001, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

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.]

Clinical Trial
The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

Dental Care and Treatment
Dental benefits available to all [Members]
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.

Additional benefits for a Child under age 6
For a Member who is severely disabled or who is a Child under age 6, We cover:
c) general anesthesia and Hospitalization for dental services; and
d) 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.

[Note to Carriers: The following dental benefits section for members through end of the month in which the Member turns age 19 would provide non-network dental benefits. Such non-network dental benefits are not required, but may be included at the option of the carrier.]

[Dental Benefits available to [Members] through end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.
- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.

- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

h) *Clinical oral evaluations once* every 6 months *
   6. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   7. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   8. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   9. Limited oral evaluations that are problem focused
   10. Detailed oral evaluations that are problem focused

i) Diagnostic Imaging with interpretation
   9. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   10. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   11. Additional films/views needed for diagnosing can be provided as needed.
   12. Bitewings, periapicals, panoramic and cephlometric radiographic images
   13. Intraoral and extraoral radiographic images
   14. Oral/facial photographic images
   15. Maxillofacial MRI, ultrasound
   16. Cone beam image capture

j) Tests and Examinations

k) Viral culture

l) Collection and preparation of saliva sample for laboratory diagnostic testing

m) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

n) Oral pathology laboratory
   4. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   5. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   6. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

f) Dental prophylaxis once every 6 months*

g) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

h) Fluoride varnish once every 3 months for children under the age of 6

i) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

j) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   5. fixed – unilateral and bilateral
   6. removable – bilateral only
   7. recementation of fixed space maintainer
   8. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite

restorations are placed on the same tooth.

- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

q) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
r) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
s) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
t) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    4. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    5. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    6. Provisional crowns are not covered.
u) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
v) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
w) Core buildup including pins
x) Pin retention
y) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
z) Additional fabricated (custom fabricated/cast) and prefabricated post
aa) Post removal
bb) Temporary crown (fractured tooth)
cc) Additional procedures to construct new crown under existing partial denture
dd) Coping
ee) Crown repair
ff) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

p) Therapeutic pulpotomy for primary and permanent teeth
q) Pulpal debridement for primary and permanent teeth
r) Partial pulpotomy for apexogensis
s) Pulpal therapy for anterior and posterior primary teeth
t) Endodontic therapy and retreatment
u) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
v) Apexification: initial, interim and final visits
w) Pulpal regeneration
x) Apicoectomy/Periradicular Surgery
y) Retrograde filling
z) Root amputation
aa) Surgical procedure for isolation of tooth with rubber dam
bb) Hemisection
cc) Canal preparation and fitting of preformed dowel or post
dd) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

d) Surgical services
    15. Gingivectomy and gingivoplasty
    16. Gingival flap including root planning
    17. Apically positioned flap
    18. Clinical crown lengthening

19. Osseous surgery
20. Bone replacement graft – first site and additional sites
21. Biologic materials to aid soft and osseous tissue regeneration
22. Guided tissue regeneration
23. Surgical revision
24. Pedicle and free soft tissue graft
25. Subepithelial connective tissue graft
26. Distal or proximal wedge
27. Soft tissue allograft
28. Combined connective tissue and double pedicle graft

e) Non-Surgical Periodontal Service
5. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
6. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
7. Full mouth debridement to enable comprehensive evaluation
8. Localized delivery of antimicrobial agents

f) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

m) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

n) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
4. Resin base and cast frame dentures including any conventional clasps, rests and teeth
5. Flexible base denture including any clasps, rests and teeth
6. Removable unilateral partial dentures or dentures without clasps are not considered

o) Overdenture – complete and partial

p) Denture adjustments –6 months after insertion or repair

q) Denture repairs – includes adjustments for first 6 months following service

r) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

s) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

t) Precision attachment, by report

u) Maxillofacial prosthetics - includes adjustments for first 6 months following service
13. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
14. Obturator prosthesis: surgical, definitive and modifications
15. Mandibular resection prosthesis with and without guide flange
16. Feeding aid
17. Surgical stents
18. Radiation carrier
19. Fluoride gel carrier
20. Commissure splint
21. Surgical splint
22. Topical medicament carrier
23. Adjustments, modification and repair to a maxillofacial prosthesis
24. Maintenance and cleaning of maxillofacial prosthesis

v) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

w) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.

2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

x) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

s) Extraction of teeth:
5. Extraction of coronal remnants – deciduous tooth,
6. Extraction, erupted tooth or exposed root
7. Surgical removal of erupted tooth or residual root
8. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

t) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

u) Other surgical Procedures
12. Oroantral fistula
13. Primary closure of sinus perforation and sinus repairs
14. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
15. Surgical access of an unerupted tooth
16. Mobilization of erupted or malpositioned tooth to aid eruption
17. Placement of device to aid eruption
18. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
19. Surgical repositioning of tooth/teeth
20. Transseptal fiberotomy/supra crestal fiberotomy
21. Surgical placement of anchorage device with or without flap
22. Harvesting bone for use in graft(s)

v) Alveoloplasty in conjunction or not in conjunction with extractions

w) Vestibuloplasty

x) Excision of benign and malignant tumors/lesions

y) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

z) Destruction of lesions by electrosurgery

aa) Removal of lateral exostosis, torus palatinus or torus madibularis

bb) Surgical reduction of osseous tuberosity

cc) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

dd) Surgical Incision
5. Incision and drainage of abcess - intraoral and extraoral
6. Removal of foreign body
7. Partial ostectomy/sequestrectomy
8. Maxillary sinusotomy

ee) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

ff) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
6. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
7. Manipulation under anesthesia
8. Condylectomy, discectomy, synovectomy
9. Joint reconstruction
10. Services associated with TMJD treatment require prior authorization

gg) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

hh) Arthroscopy

ii) Occlusal orthotic device – includes placement and removal to same provider

jj) Surgical and other repairs
16. Repair of traumatic wounds – small and complicated
17. Skin and bone graft and synthetic graft
18. Collection and application of autologous blood concentrate
19. Osteoplasty and osteotomy
20. LeFort I, II, III with or without bone graft
21. Graft of the mandible or maxilla – autogenous or nonautogenous
22. Sinus augmentations
23. Repair of maxillofacial soft and hard tissue defects
24. Frenectomy and frenoplasty

25. Excision of hyperplastic tissue and pericoronal gingiva
26. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
27. Emergency tracheotomy
28. Coronoidectomy
29. Implant – mandibular augmentation purposes
30. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

j) Limited treatment for the primary, transitional and adult dentition
k) Interceptive treatment for the primary and transitional dentition
l) Minor treatment to control harmful habits
m) Continuation of transfer cases or cases started outside of the program
n) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
o) Orthognathic Surgical Cases with comprehensive orthodontic treatment
p) Repairs to orthodontic appliances
q) Replacement of lost or broken retainer
r) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

m) Palliative treatment for emergency treatment – per visit
n) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
o) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
p) Consultation by specialist or non-primary care provider

q) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
  - o For cases that are treated in a facility.
  - o For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
  - o General anesthesia and outpatient facility charges for dental services are covered
  - o Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

r) Drugs
- Therapeutic parenteral drug
  - o Single administration
  - o Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

s) Application of desensitizing medicament – per visit
t) Occlusal guard – for treatment of bruxism, clenching or grinding
u) Athletic mouthguard covered once per year
v) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

w) Odontoplasty
x) Internal bleaching]

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Coverage
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a female Member– who is 40 years of age
b) one mammogram, every year, for a female Member age 40 and older; and
c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

Colorectal Cancer Screening Charges
We cover charges made 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. Benefits will be paid, 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 charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;

g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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 [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.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a [Member] may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Member 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.

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 written home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.
Therapy Services
Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

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.

[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.
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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per [Calendar] [Plan] 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 Contract.

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 Contract.

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 therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:

d) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
e) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
f) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.

If a Member:

d) is eligible for early intervention services through the New Jersey Early Intervention System; and
e) has been diagnosed with autism or other developmental disability; and
f) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a Covered Charge under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.
NOTE: ANY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in this Contract. We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.

We will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Contract.

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, bone density testing and Nicotine Dependence Treatment. [But We limit what We pay each [Calendar] [Plan] Year to:

a) $750 per [Member] for a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1, and
b) $500 per [Member] for all other [Member]s.]

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. [The $750 and $500 limits do not apply to services from a Network Provider.] *[Carriers may elect to cover non-network preventive care without any dollar limits.]*

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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.

Hearing Aids
We cover charges for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months.. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

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 [Member] should undergo a vision examination.

Vision Benefit
Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Covered Persons through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period.

We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich

Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. **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 Contract.**
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[h) Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
i) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, this Contract will cover the donor's medical costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THIS CONTRACT.

[**Abortion**, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]
Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

The amount of any charge which is greater than an **Allowed Charge** with respect to all [Non-Network] benefits.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a [Member].

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

Completion of claim forms.

[**Preventive contraceptive services and supplies** that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]

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 learning disabilities except as otherwise stated in this Contract.

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 except as otherwise covered under this Contract.

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 as otherwise covered under this Contract; 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 the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

Except as otherwise stated in the Hearing Aids and Newborn Hearing Screening provisions, 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. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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.**

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment**, except as otherwise stated in the Preventive Care section of this Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.
Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
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.
[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed
g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home or similar institution
- a provider' office.

i) Charges for:
- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.
k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.
m) Charges for any drug used in connection with baldness.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the
o)Member taking part in the commission of a felony.
p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
q) Charges for drugs dispensed to a Member while on active duty in any armed force.
r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.
s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract
t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.
u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Provider** except as specified in this Contract.

Services related to **Private Duty Nursing**, except as provided in the Home Health Care sections of this Contract.

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

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

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

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of this Contract, **Routine Examinations** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; or pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid 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) 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.
e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and

• Subject to Our Pre-Approval, eligibility for full-time student status, provided the [Member] is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by Us are Non-Covered Charges..**

Services provided by a **Social Worker**, except as otherwise stated in this Contract.

Stand-by services required by a Provider.

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

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

[**Telephone** consultations. [except as stated in the Outpatient Services provision].]

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**, or an act of war, if the Illness or Injury occurs while the Member is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area.

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 surgery sections of this Contract and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

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

[IMPORTANT NOTICE ***APPLICABLE ONLY TO [NON-NETWORK] BENEFITS***

[This Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a [Member]:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under this Contract. See the **Utilization Review Features** section for details.]

[This Contract has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a [Member'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 Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of this Contract. Read this Contract carefully and keep it available when consulting a Practitioner.

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

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with this Contract's utilization review features, he or she will not be eligible for full benefits under this Contract.

Compliance with this Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under this Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Contract.

Definitions

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

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Contract is not payable under this Contract.

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

Grievance Procedure
Carriers must include the disclosure requirements set forth in N.J.A.C. 11:24-3.2.

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Contract.

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review
The [Member] or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time [ABC] is notified of such admission.

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

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

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.
[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, **by 50%]** if:
a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges **by 50%],** if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

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

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet this Contract's Maximum Out of Pocket or Cash Deductible.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Contract.

We require a [Member] to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] may obtain a second surgical opinion. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

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

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

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

Penalties for Non-Compliance
As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Contract's Maximum Out of Pocket or Cash Deductible.

[SPECIALTY CASE MANAGEMENT

Important Notice: No [Member] 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 [Member] in connection with a Catastrophic Illness or Injury.
b) While there are other covered services and supplies available under this Contract for the [Member's] condition, the services and supplies We offer to make available under the terms of this provision would not otherwise be payable under this Contract.

Please note: We have sole Discretion to determine whether to consider Specialty case Management for a [Member.]

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

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

Specialty Case Management Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the [Member], [DEF] will develop 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 [Member], or his or her legal guardian, if necessary;
b) the [Member'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; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges or Covered Services and Supplies, as appropriate, under the terms of this Contract.

The agreed upon Specialty Case Management treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any [Calendar] [Plan] 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 [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

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

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

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

Covered Charges
In order for charges to be considered as Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the [Member].

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Contract] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Us to coordinate what We pay or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Contract] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.

When this [Contract] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: 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 .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Member] is covered by this [Contract] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Member] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Member's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:
a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Member] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Member] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period, the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Member] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Member] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Member] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Member] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:
a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.

c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 an Allowed Charge is called an "AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Member] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that the HMO, EPO 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 and "EPO" refers to Exclusive Provider Organization .

Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPO 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 OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under this Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.
"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means services or expenses 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 and Benefits this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide **services and** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

Medicare
If the [Non-Network] benefits under this Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AFFILIATED COMPANIES
If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

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

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

AMENDMENT
The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT
No assignment or transfer by the Contractholder or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
Except as stated below, neither clerical error nor programming or systems error by the Contractholder, nor Us in keeping any records pertaining to coverage under this Contract, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Contractholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision, such return of premium will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

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.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a. to whom We provide services and supplies or pay benefits;
b. any protection and rights when the coverage ends; and
c. claim rights and requirements.

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

Responsibilities of the [Contractholder]:
As used in this provision "SBC" means the Summary of Benefits and Coverage required by federal law.

a. The [Contractholder] shall deliver to all Eligible Persons, including [Carrier] [Members], the SBC for the group health benefits provided under this [Contract], as required by federal law or regulations, in a timely and appropriate manner. The [Contractholder] shall distribute SBCs under this provision: to all Eligible Persons with any written application materials for enrollment (including open enrollment); to special enrollees; [and] upon renewal of coverage [; and upon request].

b. The [Contractholder] shall distribute applicable SBCs, upon request and at any other times, to Eligible Persons who are not currently enrolled with [Carrier].

c. The [Contractholder] agrees to certify to [Carrier] upon [Carrier's] request that the [Contractholder] has provided the SBC as required under the [Contract] and by law. The [Contractholder] agrees to submit information upon [Carrier's] request showing that the [Contractholder] has provided the SBC, as required under the [Contract] and by law.

GOVERNING LAW
This entire Contract is governed by the laws of the State of New Jersey.
INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.
If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a [Member]: To the last address provided by the [Member] on an enrollment or change of address form actually delivered to Us.

OFFSET
We reserve the right, before paying [Non-Network] benefits to a [Member], to use the amount of payment due to offset a [Non-Network] claims payment previously made in error.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

[Network] Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries, affiliates, or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Contract because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder;
c. the Employee is covered under Medicare;
d. the Employee is covered under Medicaid or NJ FamilyCare;
e. the Employee is covered under Tricare; or
f. the Employee is covered under another group **[or individual]** health benefits plan.

[Carrier] will count this person as being covered by this Contract for the purposes of satisfying participation requirements.
[Note to carriers: Variable text in item f applies to SHOP policies only.]

PARTICIPATION REQUIREMENTS
At least 75% of the Employees eligible for insurance must be enrolled for coverage. Employees who are:
a. covered as a Dependent under a spouse's group healthcoverage,
b. covered under Medicare
c. covered under Medicaid or NJ FamilyCare;
d. covered under Tricare; or
e. covered under another group health benefits plan.

are excluded from the calculation of the participation requirement.
[Note to Carriers: Use the above participation requirements provision for SHOP policies.]

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

Premium Refunds
If one or more of the premiums paid include charges for an Employee [and or Dependent] whose coverage has ended before the due date of that premium, any refund of premium will depend on whether the Employee contributed toward the premium payment or whether it was paid in full by the Contractholder.
If the Employee contributed toward the premium payment, [Carrier] will not refund the premium and coverage will continue in force through the end of the period for which premium has been contributed by the Employee.

If the premium was paid in full by the Contractholder, any refund of premium will depend on whether claims were incurred during the period of no more than two months for which refund is requested. If no claims have been incurred [Carrier] will refund premiums paid for a maximum of two months prior to the date [Carrier] receives written notice from the Contractholder that the Employee's [and or Dependent's] coverage has ended. If claims have been incurred during the period prior to [Carrier's] receipt of written notice that the Employee [and Dependent's] coverage has ended, [Carrier] shall not be required to refund premium to the Contractholder.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at [Our] [XYZ's] office [or to one of our authorized agents.] A premium payment is due on each premium due date stated on the first page of this Contract. The Contractholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Contractholder is liable to pay premiums for the time this Contract is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for contracts issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Contract will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for contracts issued inside the SHOP]*

[REINSTATEMENT
If the premium has not been paid before the end of the grace period, this Contract automatically terminates as of the last day of the grace period. The Contractholder may make written request to Us that the Contract be reinstated. If We accept the request for reinstatement, the Contractholder must pay all unpaid premiums back to the date premium was last paid. Such payment is subject to the premium rate then in effect and to [the payment of the reinstatement fee as established by Us.] [an interest charge, determined as a percentage of the unpaid amount. The percentage will be determined by Us but will not be more than the maximum percentage allowed by law.]

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the **Schedule of Premium Rates and Classification** section of the Contract. We have the right to prospectively change Premium rates as of any of these dates:

a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) any date that the extent or nature of the risk under the Contract is changed:
- by amendment of the Contract; or
- by reason of any provision of law or any government program or regulation;

d) at the discovery of a clerical error or misstatement as described below.

We will give You 60 days written notice when a change in the Premium rates is made.

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to Determine the premium rates and certify status as a Small Employer. All records of the Contractholder which bear on this Contract must be open to Us for Our inspection at any reasonable time.

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

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

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

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 at the Contractholder's place of business.

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

We have the right to non-renew this Contract on the Contract Anniversary following the date the Contractholder no longer meets the requirements of a Small Employer as defined in this Contract. The Contractholder must certify to Us the Contractholder's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If the Contractholder fails to do this, We retain the right to non-renew this Contract as of the Contractholder's Contract Anniversary.

We have the right to non-renew this Contract on the Contract Anniversary date following advance written notice to the Contractholder for the following reasons:
a) subject to the statutory notification requirements, We cease to do business in the small group market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the small group market; or
c) the Board terminates a standard plan or a standard plan option.

The advance written notice for non-renewal for the reasons stated in items a and b above shall comply with the requirements of N.J.A.C. 11:21-16. The advance written notice required for the reason stated in item c above shall be the same as the notice requirements for item b above.

We have the right to non-renew this Contract on the Contract Anniversary Date subject to 60 days advance written notice to the Contractholder for the following reasons:
a) the Contractholder moves outside the state of New Jersey;
b) [less than [75%] of the Contractholder's eligible [full-time Employees are covered by this Contract. If an eligible a full-time Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
   2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder.
   3. The Employee is covered under Medicare;
   4. The Employee is covered under Medicaid or NJ FamilyCare;
   5. The Employee is covered under TRICARE; or
   6. The Employee is covered under another group [or individual] health benefits plan,

   [Carrier] will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;]
   [Note to carriers: Use the variable text in item 6 for SHOP policies only.]

c) the Contractholder does not contribute at least 10% of the annual cost of the Contract; or
d) the Contractholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Member

Note: A Contractholder will not be non-renewed for failure to meet the participation or contribution requirement if the renewal date coincides with the Employer Open Enrollment Period.

If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. The Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. We are not required to honor a request for a retroactive termination of this Contract. For prospective termination requests, this Contract will end on the date requested. The Contractholder is liable to pay premiums to Us for the time this Contract is in force. We shall give notice of the date of termination to the Contractholder no more than 30 days following the date of the termination.

Immediate cancellation will occur if the Contractholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Contract. Please refer to the **RetroactiveTermination of a [Member's] Coverage** provision which also addresses the consequences of fraud or misrepresentation.

RETROACTIVE TERMINATION OF A [MEMBER'S] COVERAGE
We will not retroactively terminate a [Member's] coverage under this Contract after coverage under this Contract take effect unless the [Member] performs an act, practice, or omission that constitutes fraud, or unless the [Member] makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation We will provide at least 30 days advance written notice to each [Member] whose coverage will be retroactively terminated.

If a Contractholder continues to pay the full premium for a [Member] who is no longer eligible to be covered the Contractholder may request a refund of premium as explained in the Premium Refunds provision. If We refund premium to the Contractholder the refund will result in the retroactive termination of the [Member's] coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

THE CONTRACT
The entire Contract consists of:
[a) the forms shown in the Table of Contents as of the Effective Date;
b)] the Contractholder's application, a copy of which is attached to the Contract;
[c)] any riders, [endorsements] or amendments to the Contract; and
[d)] the individual applications, if any, of all [Members].

Information in a Contractholder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to the Contractholder for attachment to this Contract.

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a [Member], and We furnish a copy to the [Member].

All statements will be deemed representations and not warranties.

WORKERS' COMPENSATION
The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.
CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

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

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

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

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:

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

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Contract to such provider.

PHYSICAL EXAMS
We, at Our expense have the right to examine the [Member]. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A [Member] who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.
Continuation Under CCR and any other continuation section of this Contract:

If a [Member] elects to continue his or her group health benefits under this Contract's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice
Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.
The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:
a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.
Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:
a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Contract ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;

h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.
Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union, [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:

a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to Us within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Contract [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.
We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.
If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or termination of the domestic partnership], the group health coverage for his or her former spouse ends. The former spouse may convert to an individual contract during the conversion period. The former spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date the group health coverage ends. See **Exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [•if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

MEDICARE AS SECONDARY PAYOR (Continued)

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.
A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, this Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

New Rule, R.1996 d.200, effective April 15, 1996.
See: 28 N.J.R. 27(a), 28 N.J.R. 2042(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.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).

Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2013 d.038, effective January 24, 2013.
See: 45 N.J.R. 107(b), 45 N.J.R. 332(a).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT II

[[INTRODUCTION]

What is a Point of Service Plan?
A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of ***Network Providers*** as well as the services of ***Non-Network Providers.*** Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a ***Network Provider*** (subject to any necessary authorization from his or her Primary Care Provider) or those of a ***Non-Network Provider.***

What is the difference between a Network Provider and a non-Network Provider?
A ***Network Provider*** is a doctor, other practitioner or facility that has an agreement with [Carrier] to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. A ***Non-Network Provider*** is any licensed or certified provider that does not have a specific agreement with [Carrier].

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of a ***Network provider*** rather than the services of a ***Non- Network Provider.***

How does the POS plan describe Network and Non-Network coverage?
The POS plan contains a section which describes Network coverage and sections which describe Non-Network coverage. The POS plan also contains many sections which apply to both the use of the services of ***Network Providers*** or the services of ***Non-Network Providers.***

- **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment [deductible and coinsurance] for use of a ***Network Provider*** as well as the deductible and coinsurance requirement for the use of a ***Non-Network Provider.*** The **SCHEDULE** also identifies some limitations to coverage.

- **COVERED SERVICES AND SUPPLIES.** This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of a ***Network Provider.***

- **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if her or she were to use the services of a ***Non-Network Provider.***

How does a person access Network Providers?
[Carrier] will provide a [directory] listing all the Primary Care Providers and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Provider, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying [Carrier].

Except in case of an Emergency or Urgent Care, Network services and supplies can **only** be provided by a ***Network Provider*** (subject to any necessary authorization from his or her Primary Care Provider). [While certain routine OB/GYN care may be secured without going through the PCP, all other Network services and supplies require the authorization of the PCP.]

How much will it cost for services and supplies if a person uses Network Providers?
[The Identification Card will specify the amount of the copayment, the ***Network provider*** will collect for [most] [some] services and supplies.] For [many] [some] services, after a person pays a copayment for the PCP visit, further services and supplies require no additional payment. [Home Health Care and Durable Medical Equipment are examples of such services and supplies.] [The plan may provide for deductible and coinsurance on services other than Primary Care Provider and pre-natal care services.]

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of a Non-Network Provider?
Persons covered under a POS plan may use the services of a Non-Network Provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from [Carrier], as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses Non-Network Providers?
After the payment of the applicable [Calendar] [Plan] Year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit were the first Non-Network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, [Carrier] would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a [Calendar] [Plan] Year, further charges are only subject to the applicable coinsurance. **Note:** [Carrier] pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Allowed Charge, as defined in the Contract and the Evidence of coverage.

Does the POS plan cover the same services and supplies whether a person uses in-Network providers or Non-Network providers?
The POS plan was designed to include the same services and supplies whether the person uses ***Network*** or ***Non-Network Providers.*** However, the **extent** of coverage differs for some services and supplies. For example, if a person elects to use a ***Network Provider*** for extended care services (skilled nursing care), coverage is unlimited as to number of days. If a person uses a ***Non-Network provider***, extended care services are limited to 120 days.

Since in-network services and supplies must be coordinated by a PCP, and ***Network Providers*** are familiar with in-network covered services and supplies, the list of in-Network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of network covered charges. In addition, [Carrier] is able to offer more details as to the nature and extent of the Network coverage.

For services and supplies that are subject to limitations, can a person receive both Network and Non-Network services and supplies?
The POS plan allows a person to receive any combination of in-network and out-of network services and supplies. However, for services and supplies subject to limitations, the POS plan includes offset provisions to coordinate the **total** services and supplies a person may receive.

PLEASE REFER TO THE CONTRACT [AND EVIDENCE OF COVERAGE] FOR COMPLETE INFORMATION CONCERNING THE POS PLAN AND USE OF NETWORK AND NON-NETWORK PROVIDERS.]

[Note to Carriers: The Introduction text may be included or omitted, at the option of the carrier.]

[Carrier] **HMO - POS PLAN**
[Plan Name]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)
POINT OF SERVICE (POS) EVIDENCE OF COVERAGE

[Carrier] certifies that the Employee named below is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

CONTRACTHOLDER:	[ABC Company]
GROUP CONTRACT NUMBER	[G-12345]
[EMPLOYEE	John Doe]
EVIDENCE OF COVERAGE NUMBER	C-123456]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE:	[January 1, 2016]
SERVICE AREA	[State of New Jersey]
AFFILIATED COMPANIES:	[DEF Company]

[COST OF COVERAGE
The coverage described in this Evidence of Coverage is Contributory Coverage. You will be advised of the amount of Your contribution when You enroll.]

[Carrier's address
100 Main Street, Any Town, NJ 00000-0000]

HMO/POS-EOC

[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]]

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SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)
[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Hospital		
Inpatient (unlimited days)	[$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30 Copayment / visit	Deductible/Coinsurance]
Pre-natal care	[$0] Copayment / visit	Deductible/Coinsurance
Practitioner Services	[$15] Copayment / visit	Deductible/Coinsurance
[Telemedicine Visits	[$15] Copayment / visit	N/A]
[E-Visits	[$15] Copayment / visit	N/A]
[Virtual Visits	[$15] Copayment / visit	N/A]
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$0] Copayment / visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
[Complex Imaging Services	[$30 Copayment]	Deductible/Coinsurance]
[All other] Diagnostic Services Inpatient Outpatient Visit	 $0 Copayment [$15] Copayment	 Deductible/Coinsurance Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Home Health Care	Covered; $[30] Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using separate deductible/coinsurance and maximum out of pocket for network and non-network services)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-natal care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
[Urgent Care	[$30] Copayment / visit	Deductible/Coinsurance]
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment Deductible or Coinsurance	No Deductible or Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network	
Per Member	[not to exceed $2,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]
Non-Network	
Per Member	[Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]

Coinsurance	
Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member maximum.]]

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 Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member 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] [Plan] Year.

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member Maximum.]]

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

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using common deductible and maximum out of pocket for network and non-network services but separate coinsurance)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-natal care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50]Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30] Copayment/visit	Deductible/Coinsurance]
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network and Non-Network

Per Member	[amount not to exceed $2,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

Coinsurance

Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member maximum.]]

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

LIMITATIONS ON SERVICES AND SUPPLIES
:Unless otherwise stated, the following limitations represent the maximum number of days or visits for use of any combination of Network and Non-Network Providers.

Charges for Home Health Care	60 Visits
Charges for therapeutic manipulation per [Calendar] [Plan] Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical or occupational therapy per [Calendar] [Plan] Year (combined) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note**: The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note**: The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for Preventive Care per [Calendar] [Plan] Year as follows:	
Network:	Unlimited
Non-Network: (Not subject to Cash Deductible or Coinsurance) [• for a Member who is a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1 • for all [other] Members	 $750 per Member] $500 per Member
Charges for hearing aids for Members age 15 or younger	One hearing aid per hearing impaired ear per 24-month period
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	
Network:	Unlimited
Non-Network:	Unlimited

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PROVIDER . READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

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

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

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

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:
a)the center's actual daily room and board charge; or
b)50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

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.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

ALLOWED CHARGE. With respect to [Network] services and supplies, the negotiated arrangement.

With respect to [Non-Network] benefits, Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance 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 an Allowed Charge under this Contract. For charges that are not determined by a negotiated fee schedule, theMember may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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 the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

[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.]

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

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Benefits Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

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 or the percentage of Covered Charges, as applicable, that must be paid by a [Member]. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

[COMPLEX IMAGING SERVICES. Any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Allowed Charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to [Non-Network] benefits. The services and supplies must be:
a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

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

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

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 a [Member] meet a [Member's] routine daily needs; or
b)can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT. Your:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended; and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b)Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].
Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

Your "Dependent child" includes Your legally adopted child, Your step-child, Your foster child, the child of his or her civil union partner, [and] [, the child of his or her domestic partner, and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

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]:
   1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
   2. attains age 26 for all other provisions;
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 care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under the Contract if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We 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 as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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

EFFECTIVE DATE. The date on which coverage begins under the Contract for the Contractholder, or the date coverage begins under the Contract for a [Member], as the context in which the term is used suggests.

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.

[EMPLOYEE. A Full-Time bona-fide Employee (25 hours per week) of the Contractholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Contract. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[EMPLOYEE. An Employee of the Contractholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

EMPLOYEE OPEN ENROLLMENT PERIOD. The 30-day period each year designated by the Contractholder during which:
a) Employees and Dependents who are eligible under the Contract but who are Late Enrollees may enroll for coverage under the Contract; and
b) Employees and Dependents who are covered under Contract may elect coverage under a different policy, if any, offered by the Contractholder.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment;
b)[the day] after any applicable waiting period ends; or
c) [the day] after any applicable Orientation Period ends.

EMPLOYER. [ABC Company].

EMPLOYER OPEN ENROLLMENT PERIOD. The period from November 15 through December 15 each year beginning in 2014.

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the [Member's] Enrollment Date does not change.

[E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and [Members] who are established patients of the Provider.]

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:
a) The American Hospital Formulary Service Drug Information; or
b) 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 non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

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

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

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing 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.

FULL-TIME. A normal work week of [25] [30] or more hours. Work must be at the Contractholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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 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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar Contract, policy, or plan issued to a Small Employer, 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; 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 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 the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

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 disease. Illness includes Mental Illness.

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

INJURY 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 health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

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

[LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[MAIL ORDER PROGRAM. A program under which a [Member] can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

[MAINTENANCE DRUG. Only a Prescription Drug used for the treatment of chronic medical conditions.]

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

[MEMBER]. An eligible person who is covered under the Contract (includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with Mental Illness. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL ILLNESS. A behavioral, psychological or biological dysfunction. Mental illness includes a biologically-based mental illness as well as a mental illness that is not biologically-based. With respect to mental illness that is biologically based, mental illness means a 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.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. The Employee will have access to up to date lists of [Network] Providers.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

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

NON-COVERED CHARGES. Charges which do not meet the Contract's definition of Covered Charges or which exceed any of the benefit limits shown in the Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by the Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in the Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

[NON-PREFERRED DRUG. A drug that has not been designated as a Preferred Drug.]

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.

[ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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.

[PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:

a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[**PARTICIPATING PHARMACY.** A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PLAN SPONSOR.
Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. § 1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Our approval using paper or electronic means for specified services and supplies prior to the date the 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 by payable under the Contract. For more information regarding the services for which We require Pre-Approval, consult the website at [www.xxx.com]]

[**PREFERRED DRUG.** A Prescription Drug that; a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Members, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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. As used in this Contract preventive care means:
a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: 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.

PRIMARY CARE PROVIDER (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Members who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Provider in conformance with Our policies and procedures that direct 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."

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, and supportive devices for the foot.

ROUTINE NURSING CARE. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of 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.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

[**SMALL EMPLOYER.** Means:

a) In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar] Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year; OR

b) In connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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

SPECIALIST DOCTOR. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females].

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Contractholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Contractholder.

[SPECIALTY PHARMACETICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn'sDisease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a)be accredited for its stated purpose by the Joint Commission; or
b)be approved for its stated purpose by Medicare.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

[TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].

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.

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

TRIGGERING EVENT. The following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.
d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
h) The date of a court order that requires coverage for a Dependent.

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

[VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the [Member] and the Provider.]

[WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. An Employee who is covered under the Contract.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] [and] [who live, work or reside in the Service Area] will be eligible if the Employees are [Actively at Work] Full-Time Employees. [In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,]We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

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

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment;

We will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under the Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under the Contract and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Contract, We will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;

d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee must enroll under the Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under the Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.
In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

[The [Orientation Period and]Waiting Period
The Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under the Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under the Contract. But, if the Contract uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and] working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, We will postpone the start of his or her coverage until he or she returns to Active Work.]

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

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

If the Employee does this more than [30] days after the Employee's Eligibility Date, We will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement

The Exception applies if the Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:

a) the Employee was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Contract.]

Exception: If the coverage under the Contract is richer than the coverage under the Contractholder's old plan, the Contract will provide coverage for services and supplies related to the disabling condition. The Contract will coordinate with the Contractholder's old plan, with the Contract providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends

An Employee's coverage under the Contract will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under the Contract.
c) the date the Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) the last day of the period for which required payments have been made for the Employee, subject to the **Payment of Premium - Grace Period** section.
e) [the date] an Employee no longer lives, works or resides in the Service Area.]

[DEPENDENT COVERAGE

Contractholder Election

A Contractholder that elects to make Dependent coverage available under the Contract may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Contractholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Contract is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are:

a) Your legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   - the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended); and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.
b) Your Dependent children who are under age 26.

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children, Step-Children, Foster Children

Your "unmarried Dependent children" include Your legally adopted children, Your step-children, Your foster children, the child of his or her civil union partner, [and] [, the child of his or her domestic partner and] children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

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

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

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

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

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under the Contract. We consider an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

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

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under the Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under the Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in the Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

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

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under the Contract, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

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

In addition, if an Employee initially waived coverage under the Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under the Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for an Employee's Dependent coverage to begin, the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Contract, the date an Employee's Dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Contractholder's Contract Anniversary date following enrollment.

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

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

The coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Contract.

Newborn Children
We will cover an Employee's 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:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under the Contract.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
1) give written notice to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the 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, the child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's coverage under the Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date the Contract ends;
[d)]. the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. At 12:01 a.m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Dependent spouse, the date the spouse moves his or her permanent residence outside the Service Area.]

EXTENDED HEALTH BENEFITS

If the Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the [Member].
c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes material information that is either incorrect or incomplete in a statement made for the purpose of effecting coverage under the Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider 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 Provider 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 Provider and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Provider.

[Members] select a Primary Care Provider 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 Provider initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Provider selection. [If a [Member] fails to select a Primary Care Provider, We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Provider, [Members] can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Provider 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.

[NETWORK
The Member will have access to given up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]]

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to the Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under the Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are [Members]. To be eligible for services or benefits under the Contract, the holder of the card must be a [Member] on whose behalf all applicable premium charges under the Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of the Contract shall be charged for such services or benefits at prevailing rates.

If any [Member] permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such [Member] and his or her Dependents, if any, pursuant to the Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] Providers or entities with whom We have arranged for services under the Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under the Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

REFERRAL FORMS

A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Provider.

Except in the case of an Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.

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 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 the 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 the Contract. In such event, We will continue to provide all benefits covered by the 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 the Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of 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 may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Provider or a Provider referred in writing by the Primary Care Provider without notifying the [Member] that such benefit would not be covered under the Contract.

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 Providers 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. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

[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 the 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 the Contract, whichever occurs first.

We shall not continue services in those instance 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 the 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.]

COVERED SERVICES AND SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [Cash Deductible] [or Coinsurance] as stated in the applicable Schedule and subject to the terms, conditions and limitations of the Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

[COVERAGE PROVISION

[The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

The Cash Deductible

Each [Calendar] [Plan] 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] [Plan] 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 Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Members in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of this Contract.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]

(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)
[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)

[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] [Plan] 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 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] [Plan] Year.]

[Once Members in a family meet two times the individual Maximum Out of Pocket, no 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] [Plan] Year.]

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached,

the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no 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] [Plan] Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network or [Tier 2] Network Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] Covered Services and Supplies for the remainder of the [Calendar] [Plan] Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.
Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.

[Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] 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 and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA.]

If This Plan Replaces Another Plan
The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The Member may have incurred charges for covered services and supplies under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred during the [Calendar] [Plan] Year in which this Contract starts or during the 90 days preceding the effective date whichever is the greater period;
b) this Contract would have provided coverage for the charges if this Contract had been in effect:
c) the Member was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.]

Note to carriers: The Coverage Provision section is only to be included in plans where Network coverage is subject to deductible and coinsurance.]

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Provider's office selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Provider.

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
2) **Home visits** by a [Member's] Primary Care Provider.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine gynecological 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 Provider and Pre-Approved by Us.
7) **Procedures and Prescription Drugs to enhance fertility**, except where specifically excluded in the Contract. [Subject to Pre-Approval,] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. . The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8) **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance. The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist in Our Network. Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.
9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
10) [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** [including **contraceptives**] ***[Note to carriers: Omit if requested by a religious employer.]*** **which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]
[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] [Network] Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

[We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee 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 the 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 the Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in the 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.
[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.]

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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 Provider and approved in advance by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
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) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services

incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

21) **Orally Administered Anti-Cancer Prescription Drugs** As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs do not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Member is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs.
[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Network coverage the Contract provides for intravenously administered or injected anti cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Network copayment, deductible and/or coinsurance for intravenously administered or injected anti cancer medications the Member will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

22) **Vision Benefit** Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

23) **Mammogram Coverage**
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Provider.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** Except as stated below, the following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Provider, only at [Network] Hospitals and [Network] Facilities (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.
Exception: If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

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 the Contract, We also provide coverage for the mother and newly born child for:
⇒ a minimum of 48 hours of Inpatient care in a [Network] Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of Inpatient care in a [Network] Hospital following a cesarean section.
• We provide childbirth and newborn coverage subject to the following:
⇒ the attending Practitioner must determine that Inpatient care is medically necessary; or
⇒ the mother must request the Inpatient care.
• [As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]
2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing 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 Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services.
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.

We also cover 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.

20.The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
21.Allogeneic bone marrow transplants.
[22. 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.]

[22 or 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;
[23 or 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.]
[24. or 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 MENTAL ILLNESS OR SUBSTANCE ABUSE.** We cover treatment of a Mental Illness or Substance 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 Provider. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Provider in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Provider 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 Provider[or Us] prior to seeking Emergency treatment.
II. We will cover the cost of services and supplies in connection with an Emergency provided within or outside our service area without a prior 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 the Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
C. We and a [Member's] Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for services received unless We Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
III. In the event a [Member] is hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of the Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior 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 Member has a potentially life-threatening condition. Information on the use of the "911" system is included in the identification card.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Provider . 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.
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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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 or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.
(g) DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
c) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.
Member Person:
a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a Covered Service under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

NOTE: ANY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Provider. 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.
Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

NOTE: ANY HOME HEALTH CARE BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE HOME HEALTH CARE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

i.) 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 Provider. 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.

(j) **DENTAL CARE AND TREATMENT.**
Dental benefits available to all [Members]

The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care **Provider.** 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.

[Dental Benefits available to [Members] through end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.
- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused
b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening
    5. Osseous surgery
    6. Bone replacement graft – first site and additional sites
    7. Biologic materials to aid soft and osseous tissue regeneration
    8. Guided tissue regeneration
    9. Surgical revision
    10. Pedicle and free soft tissue graft

11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b) Non-Surgical Periodontal Service
1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.

5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects
   9. Frenectomy and frenoplasty
   10. Excision of hyperplastic tissue and pericoronal gingiva
   11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
   12. Emergency tracheotomy
   13. Coronoidectomy

14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
    - Hospital or ambulatory surgical center call

- o For cases that are treated in a facility.
- o For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
- o General anesthesia and outpatient facility charges for dental services are covered
- o Dental services rendered in these settings by a dentist not on staff are considered separately

- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - o Single administration
  - o Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted if a stand-alone dental plan is bought. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a Child under age 6]
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.

(k) **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 Provider. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l)**THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Provider. We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

(m) [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, with 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 the Contract for treatments that are not Experimental or Investigational.]

(n) CLINICAL TRIAL The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

[NON-NETWORK] BENEFIT PROVISION *APPLICABLE TO [NON-NETWORK] BENEFITS*

The Cash Deductible
Each [Calendar] [Plan] Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by the Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that [Member], less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while that [Member] is covered by the Contract. And what We pay is based on all the terms of the Contract.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:
a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the [Calendar] [Plan] Year in which the Contract starts;
b) the charges would have been considered Covered Charges under the Contract if the Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit
The Contract has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two [Members] in a family meet their individual Cash Deductibles in a [Calendar] [Plan] 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] [Plan] Year. What We pay is based on all the terms of the Contract.]

[Per Covered Family

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

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.]

[Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.]

[Note to carriers: Use the above For Single Coverage Only and Other than Single Accumulation, For example, the text would be included if the plan is a high deductible health plan that could be used in conjunction with an HSA]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Member 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] [Plan] Year.

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no 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] [Plan] Year.]]
[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] [Plan] Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the [Calendar] [Plan] Year.

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no 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] [Plan] Year.]]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

COVERED CHARGES ***APPLICABLE TO [NON-NETWORK] BENEFITS***

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of the Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in the Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement. If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

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 Provider, determine that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of 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 childbirth and newborn care 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 [Member] incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment[, subject to the Contract's **Emergency Room Copayment Requirement** section].

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. The Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

[Emergency Room Copayment Requirement
Each time a [Member] uses the services of a Hospital emergency room, he or she must pay the Copayment shown in the Schedule 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 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. [Carrier] 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 Member 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 cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

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 the Contract.

Home Health Care Charges:
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Member 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 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.
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.
We do not pay for:
A. services furnished to family members, other than the patient; or
B. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.
Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

ANY HOME HEALTH CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE HOME HEALTH CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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 Contract.

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.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

[Carrier] does 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.

[Carrier] covers 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.

We also cover 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.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally Ill" or "terminally Injured" means that the [Member's] Practitioner has certified in writing that the [Member's] life expectancy is six months or less.

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

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

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

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 the Contract.

Mental Illness or Substance Abuse
We pay benefits for the Covered Charges a [Member] incurs for the treatment of mental Illness or Substance 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.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;

c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

Pregnancy
The Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of the Contract, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

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 [Member].

Charges for the Treatment of Hemophilia
[Carrier] covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

[[Carrier] 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 the [Carrier's] 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 [Carrier's] network clinical laboratory.

[Carrier] will pay the Hospital's clinical laboratory for the laboratory services at the same rate [Carrier] would pay a Network clinical laboratory for comparable services.]

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a [Member] to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) 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.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

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 the Contract.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Contract.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of the Contract.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

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 the Contract.
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 the [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.

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 [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
c) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
d) 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 the Contract'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] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to the Employee before adding 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 the 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 the Contract. The [Member] may appeal the decision by following the Appeals Procedure process set forth in the Contract.]

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states "Dispense as Written" on the prescription the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]
[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.]

[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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.

Orally Administered Anti-Cancer Prescription Drugs
As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs do not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Member is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.

[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Non-Network coverage the Contract provides for intravenously administered or injected anti cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Non-Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Non-Network copayment, deductible and/or coinsurance for intravenously administered or injected anti cancer medications the Member will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2001, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

[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 the Contract for treatments that are not Experimental or Investigational.]

Clinical Trial
The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

Dental Care and Treatment
Dental benefits available to all [Members]
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Additional benefits for a Child under age 6
For a Member who is severely disabled or who is a Child under age 6, We cover:
c) general anesthesia and Hospitalization for dental services; and
d) 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.

[Note to Carriers: The following dental benefits section for members through the end of the month in which the Member turns age 19 would provide non-network dental benefits. Such non-network dental benefits are not required, but may be included at the option of the carrier.]

[Dental Benefits available to [Members] through *the end of the month in which the Member turns age 19*

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

h) *Clinical oral evaluations once* every 6 months *
   6. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   7. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   8. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   9. Limited oral evaluations that are problem focused
   10. Detailed oral evaluations that are problem focused

i) Diagnostic Imaging with interpretation
   9. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   10. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   11. Additional films/views needed for diagnosing can be provided as needed.
   12. Bitewings, periapicals, panoramic and cephlometric radiographic images
   13. Intraoral and extraoral radiographic images
   14. Oral/facial photographic images
   15. Maxillofacial MRI, ultrasound
   16. Cone beam image capture

j) Tests and Examinations

k) Viral culture

l) Collection and preparation of saliva sample for laboratory diagnostic testing

m) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

n) Oral pathology laboratory
   4. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   5. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   6. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

f) Dental prophylaxis once every 6 months*

g) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

h) Fluoride varnish once every 3 months for children under the age of 6

i) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

j) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   5. fixed – unilateral and bilateral
   6. removable – bilateral only
   7. recementation of fixed space maintainer
   8. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.

- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

q) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
r) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
s) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
t) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    4. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    5. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    6. Provisional crowns are not covered.
u) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
v) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
w) Core buildup including pins
x) Pin retention
y) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
z) Additional fabricated (custom fabricated/cast) and prefabricated post
aa) Post removal
bb) Temporary crown (fractured tooth)
cc) Additional procedures to construct new crown under existing partial denture
dd) Coping
ee) Crown repair
ff) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

p) Therapeutic pulpotomy for primary and permanent teeth
q) Pulpal debridement for primary and permanent teeth
r) Partial pulpotomy for apexogensis
s) Pulpal therapy for anterior and posterior primary teeth
t) Endodontic therapy and retreatment
u) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
v) Apexification: initial, interim and final visits
w) Pulpal regeneration
x) Apicoectomy/Periradicular Surgery
y) Retrograde filling
z) Root amputation
aa) Surgical procedure for isolation of tooth with rubber dam
bb) Hemisection
cc) Canal preparation and fitting of preformed dowel or post
dd) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

d) Surgical services
    15. Gingivectomy and gingivoplasty
    16. Gingival flap including root planning

17. Apically positioned flap
18. Clinical crown lengthening
19. Osseous surgery
20. Bone replacement graft – first site and additional sites
21. Biologic materials to aid soft and osseous tissue regeneration
22. Guided tissue regeneration
23. Surgical revision
24. Pedicle and free soft tissue graft
25. Subepithelial connective tissue graft
26. Distal or proximal wedge
27. Soft tissue allograft
28. Combined connective tissue and double pedicle graft

e) Non-Surgical Periodontal Service
5. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
6. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
7. Full mouth debridement to enable comprehensive evaluation
8. Localized delivery of antimicrobial agents

f) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

m) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

n) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
4. Resin base and cast frame dentures including any conventional clasps, rests and teeth
5. Flexible base denture including any clasps, rests and teeth
6. Removable unilateral partial dentures or dentures without clasps are not considered

o) Overdenture – complete and partial

p) Denture adjustments –6 months after insertion or repair

q) Denture repairs – includes adjustments for first 6 months following service

r) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

s) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

t) Precision attachment, by report

u) Maxillofacial prosthetics - includes adjustments for first 6 months following service
13. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
14. Obturator prosthesis: surgical, definitive and modifications
15. Mandibular resection prosthesis with and without guide flange
16. Feeding aid
17. Surgical stents
18. Radiation carrier
19. Fluoride gel carrier
20. Commissure splint
21. Surgical splint
22. Topical medicament carrier
23. Adjustments, modification and repair to a maxillofacial prosthesis
24. Maintenance and cleaning of maxillofacial prosthesis

v) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

w) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
   1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
   2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
   3. Considerations and requirements noted for single crowns apply
   4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
   5. Abutment teeth must be periodontally sound and have a good long term prognosis
   6. Repair and recementation

x) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

s) Extraction of teeth:
   5. Extraction of coronal remnants – deciduous tooth,
   6. Extraction, erupted tooth or exposed root
   7. Surgical removal of erupted tooth or residual root
   8. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

t) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

u) Other surgical Procedures
   12. Oroantral fistula
   13. Primary closure of sinus perforation and sinus repairs
   14. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   15. Surgical access of an unerupted tooth
   16. Mobilization of erupted or malpositioned tooth to aid eruption
   17. Placement of device to aid eruption
   18. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   19. Surgical repositioning of tooth/teeth
   20. Transseptal fiberotomy/supra crestal fiberotomy
   21. Surgical placement of anchorage device with or without flap
   22. Harvesting bone for use in graft(s)

v) Alveoloplasty in conjunction or not in conjunction with extractions

w) Vestibuloplasty

x) Excision of benign and malignant tumors/lesions

y) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

z) Destruction of lesions by electrosurgery

aa) Removal of lateral exostosis, torus palatinus or torus madibularis

bb) Surgical reduction of osseous tuberosity

cc) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

dd) Surgical Incision
   5. Incision and drainage of abcess - intraoral and extraoral
   6. Removal of foreign body
   7. Partial ostectomy/sequestrectomy
   8. Maxillary sinusotomy

ee) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

ff) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   6. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   7. Manipulation under anesthesia
   8. Condylectomy, discectomy, synovectomy
   9. Joint reconstruction
   10. Services associated with TMJD treatment require prior authorization

gg) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

hh) Arthroscopy

ii) Occlusal orthotic device – includes placement and removal to same provider

jj) Surgical and other repairs
   16. Repair of traumatic wounds – small and complicated
   17. Skin and bone graft and synthetic graft
   18. Collection and application of autologous blood concentrate
   19. Osteoplasty and osteotomy
   20. LeFort I, II, III with or without bone graft
   21. Graft of the mandible or maxilla – autogenous or nonautogenous

22. Sinus augmentations
23. Repair of maxillofacial soft and hard tissue defects
24. Frenectomy and frenoplasty
25. Excision of hyperplastic tissue and pericoronal gingiva
26. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
27. Emergency tracheotomy
28. Coronoidectomy
29. Implant – mandibular augmentation purposes
30. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

j) Limited treatment for the primary, transitional and adult dentition
k) Interceptive treatment for the primary and transitional dentition
l) Minor treatment to control harmful habits
m) Continuation of transfer cases or cases started outside of the program
n) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
o) Orthognathic Surgical Cases with comprehensive orthodontic treatment
p) Repairs to orthodontic appliances
q) Replacement of lost or broken retainer
r) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

m) Palliative treatment for emergency treatment – per visit
n) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided 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. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
o) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.

- Office or Clinic maximum – 2 units
- Inpatient/Outpatient hospital – 4 units
- Skilled Nursing/Long Term Care – 2 units

p) Consultation by specialist or non-primary care provider
q) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
  - For cases that are treated in a facility.
  - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
  - General anesthesia and outpatient facility charges for dental services are covered
  - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

r) Drugs
- Therapeutic parenteral drug
  - Single administration
  - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

s) Application of desensitizing medicament – per visit
t) Occlusal guard – for treatment of bruxism, clenching or grinding
u) Athletic mouthguard covered once per year
v) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

w) Odontoplasty
x) Internal bleaching]

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Coverage
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
d) one baseline mammogram for a female Member– who is 40 years of age
e) one mammogram, every year, for a female Member age 40 and older; and
f) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:
e) an ultrasound evaluation;
f) a magnetic resonance imaging scan;
g) a three-dimensional mammography; and
h) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.
d) The mammogram demonstrates extremely dense breast tissue;
e) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
f) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

Colorectal Cancer Screening Charges
We cover charges made 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. Benefits will be paid, 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 charges for:

a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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 [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.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a [Member] may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Member 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.

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 written home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

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

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.

[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.
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 Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per [Calendar] [Plan] 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..
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 Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per [Calendar] [Plan] 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 the Contract.

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 the Contract.

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 therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision..

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another developmental disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
d) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
e) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
f) speech therapy where speech therapy refers to treatment of a Member's speech impairment.
Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.

If a Member:
d) is eligible for early intervention services through the New Jersey Early Intervention System; and
e) has been diagnosed with autism or other developmental disability; and
f) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a Covered Charge under this Contract. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

NOTE: ANY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in the Contract. We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of the Contract.

We will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by Us provided that benefits would otherwise be payable under the Contract.

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, bone density testing and Nicotine Dependence Treatment. [But We limit what We pay each [Calendar] [Plan] Year to:
a) $750 per [Member] for a Dependent child from birth until the end of the [Calendar] [Plan] Year in which the Dependent child attains age 1, and
b) $500 per [Member] for all other [Member]s.]

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. [The $750 and $500 limits do not apply to services from a Network Provider.] *[Carriers may elect to cover non-network preventive care without any dollar limits.]*

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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.

Hearing Aids
We cover charges for medically necessary services incurred in the purchase of a hearing aid for a [Member] age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment applicable to Durable Medical Equipment will apply to the purchase of hearing aid. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

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 [Member] should undergo a vision examination.

Vision Benefit
Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Covered Persons through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period.

We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders

- SCID
- WISCOT Aldrich

Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. **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 the Contract.**

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

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, the Contract will cover the donor's costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THE CONTRACT.

[**Abortion**, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]

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

The amount of any charge which is greater than an **Allowed Charge** with respect to all [Non-Network] benefits.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a [Member].

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

Completion of claim forms.
[Preventive contraceptive services and supplies that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in the 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 the Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in the Contract.

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

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.

Extraction of teeth, except for bony impacted teeth except as otherwise covered under this Contract..

Services or supplies for or in connection with:

a. except as otherwise stated in the Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or as otherwise covered under this Contract 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 the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and / or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal..

Except as otherwise stated in the Hearing Aids and Newborn Hearing Screening provisions, 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. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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.**

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment**, except as otherwise stated in the Preventive Care section of the Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in the 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.

[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed
g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home

- a nursing home or similar institution
- a provider' office.

i) Charges for:
- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.
k) Charges for drugs for the management of nicotine dependence.
l) Charges for topical dental fluorides.
m) Charges for any drug used in connection with baldness.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the
o)Member taking part in the commission of a felony.
p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
q) Charges for drugs dispensed to a Member while on active duty in any armed force.
r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.
s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract
t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **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.
u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Provider** except as specified in the Contract.

Services related to **Private Duty Nursing** care, except as provided in the Home Health Care sections of the Contract.
Services or supplies that are not furnished by an eligible **Provider.**

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

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

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

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid 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) 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.

e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and
- Subject to Our Pre-Approval, eligibility for full-time student status, provided the [Member] is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by [Carrier] are Non-Covered Charges..**

Services provided by a **Social Worker**, except as otherwise stated in the Contract.

Stand-by services required by a Provider.

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

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

[Telephone consultations. [except as stated in the Outpatient Services provision].]
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**, or an act of war, if the Illness or Injury occurs while the Member is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area.

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 surgery sections of the Contract and except as provided in the Nutritional Counseling and Food and Food Products for Inherited Metabolic Diseases provisions.

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

[IMPORTANT NOTICE ***APPLICABLE ONLY TO [NON-NETWORK] BENEFITS***

[The Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a [Member]:

a) is admitted as an Inpatient to a Hospital, or

b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under the Contract. See the **Utilization Review Features** section for details.]

[The Contract has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a [Member'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.]

[The Contract has centers of excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

What We pay is subject to all of the terms of the Contract. Read the Contract carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading the Contract he or she should [call The Group Claim Office at the number shown on his or her Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with the Contract's utilization review features, he or she will not be eligible for full benefits under the Contract.

Compliance with the Contract's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under the Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Contract.

Definitions

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

By "covered professional charges for Surgery" We mean charges for Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Contract is not payable under the Contract.

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

Grievance Procedure
Carriers must include the disclosure requirements set forth in N.J.A.C. 11:24-3.2.

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Contract.

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

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

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

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

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the [Member's] admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility;
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital

e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review
The [Member] or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time [ABC] is notified of such admission.

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

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

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.
[ABC] notifies the [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. [We reduce what We pay for covered Hospital charges, **by 50%]** if:
a) the [Member] does not request a pre-hospital review; or
b) the [Member] does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, [We reduce what We pay for covered Hospital charges **by 50%],** if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the [Member] does not request a continued stay review; or
c) the [Member] does not receive authorization for such continued stay.

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

For any Hospital admission, if a [Member] stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet the Contract's Maximum Out of Pocket or Cash Deductible.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a [Member] does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Contract.

We require a [Member] to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

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

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] may obtain a second surgical opinion. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified by reason of his or her specialty to give an opinion on the proposed Surgery;
b) is not a business associate of the [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

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

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of the Contract, except, these charges are not subject to the Cash Deductible or Coinsurance.

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

Penalties for Non-Compliance
As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the [Member] does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the [Member] does not get those opinions before the Surgery is done
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Contract's Maximum Out of Pocket or Cash Deductible.

[SPECIALTY CASE MANAGEMENT

Important Notice: No [Member] 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 [Member] in connection with a Catastrophic Illness or Injury.
b) While there are other covered services and supplies available under the Contract for the [Member's] condition, the services and supplies We offer to make available under the terms of this provision would not otherwise be payable under the Contract.

Please note: We have sole Discretion to determine whether to consider Specialty case Management for a [Member.]

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

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

Specialty Case Management Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the [Member], [DEF] will develop 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 [Member], or his or her legal guardian, if necessary;
b) the [Member'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; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges or Covered Services and Supplies, as appropriate, under the terms of the Contract.

The agreed upon Specialty Case Management treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any [Calendar] [Plan] 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 [Member] is required, in any way, to receive medical care and treatment at a Center of Excellence.

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

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

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

Covered Charges
In order for charges to be considered as Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the [Member].

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Contract] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Us to coordinate what We pay or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. 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.

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 any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Contract] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] 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.

When this [Contract] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: 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 .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Member] is covered by this [Contract] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Member] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Member's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:
a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Member] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Member] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN
We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period, the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan 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.

The Secondary Plan 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.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Member] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Member] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Member] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Member] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Member] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:
a) The benefits of the Plan of the parent whose birthday falls earlier in the [Calendar] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] Year.

b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a [Calendar] [Plan] Year, not the year in which the parent was born.
d)If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

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 Allowed Charge (AC), 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 an Allowed Charge is called an "AC 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." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Member] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

Payment to the provider may be based on a "capitation". This means that then HMO, EPO 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 and "EPO" refers to Exclusive Provider Organization .

Primary Plan is an AC Plan and Secondary Plan is an AC 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 an AC 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 an AC 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 an AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO 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 an AC 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 an AC 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 or EPO and Secondary Plan is an HMO or EPO
If the Primary Plan is an HMO or EPOplan 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 OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under the Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) the Contract;
b) PIP; or
c) OSAIC.

"Eligible Services or Expenses" means services or expenses provided for treatment of an Injury which is covered under the Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
The Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under the Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

If there is a dispute as to which policy is primary, the Contract will pay benefits or provide services as if it were primary.

Services and Benefits the Contract will provide if it is primary to PIP or OSAIC.
If the Contract is primary to PIP or OSAIC it will provide **services and** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.
If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

Medicare
If the [Non-Network] benefits under the Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

CLERICAL ERROR - MISSTATEMENTS
Except as stated below, neither clerical error nor programming or systems error by the Contractholder, nor Us in keeping any records pertaining to coverage under the Contract, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Contractholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision of the Contract, such return of premium will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

RETROACTIVE TERMINATION OF A [MEMBER'S] COVERAGE
We will not retroactively terminate a [Member's] coverage under the Contract after coverage under the Contract take effect unless the [Member] performs an act, practice, or omission that constitutes fraud, or unless the [Member] makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation We will provide at least 30 days advance written notice to each [Member] whose coverage will be retroactively terminated.

If a Contractholder continues to pay the full premium for a [Member] who is no longer eligible to be covered the Contractholder may request a refund of premium as explained in the Premium Refunds provision of the Contract. If We refund premium to the Contractholder the refund will result in the retroactive termination of the [Member's] coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

CONFORMITY WITH LAW
Any provision of the 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 the Contract.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a [Member] covered under the Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at [Our] [XYZ's] office [or to one of our authorized agents.] A premium payment is due on each premium due date stated on the first page of this Contract. The Contractholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. [The Contractholder is liable to pay premiums for the time this Contract is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for contracts issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Contract will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for contracts issued inside the SHOP]*

WORKERS' COMPENSATION
The health benefits provided under the Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

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

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Contractholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

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

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Contract to such provider.

PHYSICAL EXAMS
We, at Our expense have the right to examine the [Member]. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

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

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

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A [Member] who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

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

If a [Member] elects to continue his or her group health benefits under this Contract's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if:
a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice
Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:
a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or
c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

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

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

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

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

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

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

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

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

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

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:
a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:
a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Contract ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

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

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities
Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union, [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any pre-existing condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage
If a Dependent Child is over the age 26 limiting age for dependent coverage and:
a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or
b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.
a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to Us within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.
If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Contract [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 31
   2. marries or enters into a civil union partnership;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under the Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under the Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Contract.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under the Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of the Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or termination of the domestic partnership], the group health coverage for his or her former spouse ends. The former spouse may convert to an individual Contract during the conversion period. The former spouse may cover under his or her individual Contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [•if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual Contract in writing and pay the first premium for such Contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual Contract will provide the medical benefits that We are required to offer. The individual Contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual Contract may still receive benefits under the Contract. If so, benefits to be paid under the individual Contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and the Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When the Contract is primary
When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a [Member] who is:
a) under age 65 except for the Employee's civil union partner [or domestic partner]or the child of the Employee's civil union partner [or domestic partner]; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or

c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner]..

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, the Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.
When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of the Contract.

[STATEMENT OF ERISA RIGHTS

The following Statement may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Carriers should include claims procedures consistent with the requirements of ERISA.]

[Carriers may include additional information consistent with the requirements of 29 C.F.R. 2590.715 – 2715.]

New Rule, R.1996 d.199, effective April 15, 1996.
See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(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.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(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).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended by R.2005 d.335, effective September 6, 2005.
See: 37 N.J.R. 3218(a), 37 N.J.R. 3834(a).
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Amended by R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
Amended by R.2009 d.278, effective August 18, 2009 (operative June 1, 2010).
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a), 42 N.J.R. 669(a).
Amended by R.2010 d.293, effective November 18, 2010 (operative April 1, 2011).
See: 42 N.J.R. 2709(a), 42 N.J.R. 3060(a).
Amended by R.2012 d.048, effective January 30, 2012 (operative July 1, 2012).
See: 43 N.J.R. 3302(a), 44 N.J.R. 596(a).
Amended by R.2012 d.178, effective September 21, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2239(a), 44 N.J.R. 2365(b).
Amended by R.2014 d.019, effective December 19, 2013 (operative January 1, 2014).
See: 46 N.J.R. 12(a), 46 N.J.R. 228(a).
Amended by R.2015 d.002, effective November 24, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2317(a), 47 N.J.R. 118(a).
Amended by R.2015 d.087, effective April 23, 2015.
See: 47 N.J.R. 881(a), 47 N.J.R. 1008(a).
Amended by R.2015 d.175, effective January 1, 2016.
See: 47 N.J.R. 2661(a), 47 N.J.R. 3033(a).

EXHIBIT JJ

(RESERVED)

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(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).
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Exhibit JJ: Explanation of Brackets HMO-Point of Service Plan".

EXHIBIT KK

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

CERTIFICATION OF NON-MEMBER STATUS

Carrier
Name _____

Address _____

_____

NAIC # _____

I, (print or type name)_____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK EITHER #1 OR #2)

_____1. Is not a "carrier" authorized to issue "health benefit plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17; **or**

_____2. Is a carrier that is not a "member" of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" in force in 1997 covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for 1997 were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above: **(YOU MUST, IN THE SPACES BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED):**

1. _____
3 _____
4. _____
5. _____

(PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF THE PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 633-1887.

Signature of officer _____ **Date**_____

Title _____ **Telephone Number** _____
Fax Number _____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health Benefits Program
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Administrative correction.
See: 30 N.J.R. 1047(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.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).