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.,
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-5.1b, Chapter 21, Small Employer Health Benefits Program, expires on August 18, 2016. See: 43 N.J.R. 1203(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.

CHAPTER TABLE OF CONTENTS

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.

"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.

"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.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).

"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.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. §1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj); chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. §§2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"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 the Federal Defense of Marriage Act, 1 U.S.C. §7, 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. Thus, for purposes of COBRA, the term "spouse" does not include a civil union partner. 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 includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but 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.

"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.

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

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(32)) and any governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of that government.

"Group health 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. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation or dissolution of a civil union or termination of a domestic partnership; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order or 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.

"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 sup-

plies in a calendar year. Except as provided in N.J.A.C. 11:22-5.2, 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. Except as provided in N.J.A.C. 11:22-5.2, 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. Except as provided in N.J.A.C. 11:22-5.2, 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.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"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)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be considered as a preexisting condition.

"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, 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 two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the

first day of the plan year, and the majority of the eligible employees are employed in New Jersey. 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. 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. 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 reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such 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.

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973, c.337 (N.J.S.A. 26:21-1 et seq.).

"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.

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

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".

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.

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 A, "The Small Group Health Benefits Basic Policy," Exhibit A and V;

2. Plan B, "The Small Group Health Benefits Policy B," Exhibit F and W;

3. Plan C, "The Small Group Health Benefits Policy C," Exhibit F and W;

4. Plan D, "The Small Group Health Benefits Policy D," Exhibit F and W;

5. Plan E, "The Small Group Health Benefits Policy E," Exhibit F and W;

6. 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;

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

8. HMO/POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibit HH and II.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer Plan A and at least two of the health benefits plans designated as Plans B, C, D and E as set forth in Exhibits A and F, V and W, in the Appendix, subject to (b)1 through 4 below and except as set forth in (c) below.

1. Plan A is the basic plan. Every member shall offer Plan A consistent with the following specifications:

i. Plan A shall contain a deductible of $250.00 per covered person and:

(1) A deductible of $500.00 per covered family, to be satisfied by two separate covered persons and a per person maximum out of pocket of $7,750; or

(2) A deductible of $750.00 per covered family, to be satisfied on an aggregate basis and a per person maximum out of pocket of $7,750.

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

i. The per covered person annual deductible shall be an amount not less than $250.00 and not greater than $5,000.

ii. The per covered family annual deductible shall be, at the option of the carrier, either:

(1) Two times the per covered person annual deductible, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person annual deductible and must be satisfied on an aggregate basis.

3. Members offering Plans B, C, and/or D shall include maximum out of pocket provisions consistent with the following specifications:

i. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

ii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iii. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iv. The per covered family maximum out of pocket shall be at the option of the carrier, either:

(1) Two times the per covered person maximum out of pocket, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person maximum out of pocket and must be satisfied on an aggregate basis.

4. Plan E may be offered. Members offering Plan E shall include a deductible of $150.00 per covered person and:

i. $300.00 per covered family, to be satisfied by two separate covered persons, with a per person maximum out of pocket of $1,650, and a family maximum out of pocket of $3,300 to be satisfied by two separate covered persons; or

ii. $450.00 per covered family, to be satisfied on an aggregate basis, with a per person maximum out of pocket of $1,650, and a family maximum out of pocket of $4,950 to be satisfied on an aggregate basis.

(c) State approved and Federally qualified 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 A 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: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, 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 $7,500, 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 be, at the option of the carrier, $50.00, $75.00 or $100.00.

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

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to 50 percent coinsurance, or a $15.00 copayment, at the option of the HMO.

(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. 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 an amount not less than $250.00 and not greater than $2,500 per covered person, and for a covered family shall not exceed two times the per covered person annual deductible, satisfied on either an individual basis or 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 $7,500 per covered person, 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) The standard health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent coinsurance, the network benefit shall not be subject to coinsurance;

2. For those services which are subject to 50 percent coinsurance, the network coinsurance shall be 30 percent;

3. The network maximum out of pocket shall not exceed $7,500 per covered person. 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; and

4. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person.

(f) An insurer with an approved selective contracting agreement, like all other carriers, shall offer at least three of the standard health benefits plans where one plan is Plan A, 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 provided that one of the plans offered is Plan A.

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 provided that one of the plans offered is Plan A; 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 provided that one of the plans offered is Plan A.

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.

(g) 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 or POS 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 or POS 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 or POS 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 or POS 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.

(h) State approved and Federally qualified 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 (h)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: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, 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 $5,000 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 be, at the option of the carrier, $50.00, $75.00 or $100.00.

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

iii. Prescription drugs covered under the HMO-POS plan, as opposed to under a separate prescription drug rider, shall be subject to the non-network deductible and coinsurance.

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".

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

(a) Members that offer health benefits Plans B, C, D and/or E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, HMO plan, or HMO POS plan as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more standard optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select the following rider, set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E):

i. Mail order and card;

ii. Card only; or

iii. Mail order only; and

2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select the following rider, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan:

i. Mail order and card;

ii. Card only; or

iii. Mail order only.

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)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 A, 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 A, 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 five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)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 A, 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," "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 A, 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 A, 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 five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)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 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 (d)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.

6. A member making an informational filing to the Board pursuant to (d)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;

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 A, 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;

v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. 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 A, 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.

(e) 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.

(f) 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.

SUBCHAPTER 3A. (RESERVED)

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits A, 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) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21-3.2(c), members shall use the standard rider form which is set forth in the Appendix to this chapter as Exhibit H.

(e) 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.

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(g) 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.

(h) 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.

(i) 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.

(j) Members that wish to use the standard Prescription Drug Rider shall use the form set forth in the Appendix to this chapter as Exhibit H.

(k) 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.

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 A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, 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 A-E, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans A-E, HMO or HMO POS contract, certificate, evidence of coverage or standard rider 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 A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board 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".

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 specified in Exhibit N of the Appendix to this chapter incorporated herein by reference.

(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 specified in Exhibit O of the Appendix to this chapter incorporated herein by reference.

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 specified in Exhibit O of the Appendix to this chapter incorporated herein by reference. 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.

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.

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 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21-1.2 or as further defined below, unless the context clearly indicates otherwise.

"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.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. §1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj), chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; and a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. §2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"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.

"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. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, termination of the employer's contribution toward coverage, death of a spouse, or divorce or legal separation; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the small employer is employed by an employer which offers multiple health benefits plans and the small employer elects a different plan during an open enrollment period; the small employer had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order. An eligible employee and his or her dependent spouse, if any, will not be considered late enrollees because the eligible employee initially waived coverage under the health benefits plan for himself or herself and any then existing dependents provided the eligible employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the plan within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Non-standard health benefits plan" means only a health benefits plan that was issued to cover one or more small employers by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy is not a preexisting condition.

"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.

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".

11:21-7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21-3A with respect to nonstandard health benefits plans, 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:

i. The small employer carrier shall refuse to issue coverage to an employer if the majority of its eligible employees are not employed within the State of New Jersey; or

ii. An HMO carrier 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 standard health benefits Plan A and at least two 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 at least two employees on the first day of the plan year.

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, 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 reasonably expected that the employer will employ on business days in the current calendar year. An employer that was not in existence during the preceding calendar year must have at least two eligible employees when completing the employer certification and on the first day of the plan year to be considered a small employer.

(b) Except as otherwise provided in N.J.A.C. 11:21-3A with respect to the issuance of non-standard health benefits plans, 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 or to two or more eligible employees of a member small employer.

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) In determining an employer's number of eligible employees, a small employer carrier shall consider in the calculation the number of independent contractors that the employer may include on its application for coverage to the extent that each independent contractor:

1. Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration;

2. Works 25 or more hours per week for the employer;

3. Works on other than a temporary or substitute basis;

4. The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage; and

5. Is not considered to be an employee by the New Jersey Department of Labor and Workforce Development pursuant to N.J.S.A. 43:21-19 and applicable law.

(d) 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, except that a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.7. Employees who are late enrollees shall be accepted for coverage by the small employer carrier, but a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.8. Small employer carriers shall not delay the effective date or eligibility date of a late enrollee until an "open enrollment" period.

(e) A small employer carrier may elect to provide coverage to a small employer's part-time employees (that is, working fewer than 25 hours per week), if the small employer covered part-time employees under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all part-time employees of all such small employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts.

2. Such covered employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(f) A small employer carrier may elect to provide coverage to a small employer's retired employees, if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all retired employees of all such employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts; and

2. Such covered retired employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(g) A small employer carrier may elect to provide coverage to retired employees and/or part-time employees of an employer that becomes a small employer subsequent to January 1, 1994, if the employer covered retired and/or part-time employees under a group health plan issued prior to January 1, 1994, under a health benefits plan renewed or reinstated by the carrier in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or a standard health benefits plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 and (f)1 and 2 above.

(h) 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.

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(c), 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; or

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

(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.

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".

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.

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.

11:21-7.7 Preexisting condition standards

(a) A health benefits plan shall not include a preexisting condition exclusion, except as provided in (b) or (c) below.

(b) A health benefits plan issued to a small employer with five or fewer eligible employees, as determined on the effective date of the plan and on each subsequent policy anniversary, may contain a preexisting condition exclusion. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

(c) A health benefits plan issued to a small employer may contain a preexisting condition exclusion that may apply to a late enrollee. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date of coverage, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage. If 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition exclusion shall apply to any such enrollee.

(d) In determining whether a preexisting condition provision applies to an eligible employee or dependent, carriers shall credit the time that person was covered under previous creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any waiting period under such plan. A carrier shall provide credit pursuant to this provision pursuant to one of the following methods:

1. A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

2. A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in Federal regulation rather than the method provided in (d)1 above. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category, of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all Federal notice requirements.

(e) A health benefits plan shall not impose a preexisting condition exclusion for the following:

1. A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

3. Pregnancy.

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.

11:21-7.8 Effective date of 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, except as provided in N.J.A.C. 11:21-7.5(d)2, 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. 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) 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 six months. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(d) 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.

(e) A small employer carrier may require that its small employer groups make monthly or quarterly premium payments through an automatic checking withdrawal option. In the event that a small employer carrier elects to require that its small employer groups pay premiums through an automatic checking withdrawal option, the small employer carrier shall apply this requirement to every small employer group, 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.

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;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements;

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.

11:21-7.12 Reporting requirements

(a) A small employer carrier shall file with the Board, quarterly no later than 45 days after the end of the fiscal quarter, the following information reported separately with respect to standard and non-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 A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

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 A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

3. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter and were uninsured for at least the three months prior to issue.

(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".

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 September 11, 1994, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first

three digits of the U.S. Postal Service zip codes or 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 zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden, and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084, and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E, HMO, or HMO-POS, on the basis of family structure according to only the following four rating tiers:

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

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.

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

(a) 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.

(b) Members that offer small employer health benefits plans in this State that do not offer individual health benefits plans as of January 4, 2009 shall:

1. File the required forms and rates to enter the individual market within 60 days following January 4, 2009; or

2. File to withdraw from the small employer market pursuant to N.J.A.C. 11:21-16 within 60 days following January 4, 2009.

New Rule, R.2009 d.278, effective August 18, 2009.
See: 41 N.J.R. 84(a), 41 N.J.R. 3444(a).

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".

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 (A, 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".

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(d)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).

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 rulemaking, 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

APPENDIX

EXHIBIT A

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [September 23, 2010]

POLICY ANNIVERSARIES: [September 23rd of each year beginning in 2011.]

PREMIUM DUE DATES: [Effective Date, and the 23rd day of the month beginning with October , 2010.]

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.]

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

POLICY INDEX

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

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 Year Cash Deductible:

•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment

-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

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 Coinsurance Cap 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	None
•for Facility charges made by:	
-a Hospital	20%
-an Ambulatory Surgical Center	20%
-a Birthing Center	20%
-an Extended Care Center or Rehabilitation Center	20%
-a Hospice	20%
•for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
-Prescription Drugs	20%
-Blood Transfusions	20%
-Infusion Therapy	20%
-Chemotherapy	20%
-Radiation Therapy	20%
• for all other Covered Charges	50%

Maximum Out of Pocket per Covered Person per each Calendar Year $7,750

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 accommodation, [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:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

[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.

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO with 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

Calendar Year Cash Deductible:	
•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250
[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment	
-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

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 Coinsured Charge Limit 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.

	If treatment, services or supplies are given by: a Network Provider	a Non-Network Provider
The Coinsurance for this Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
-a Hospital	None	20%
-An Ambulatory Surgical Center	None	20%
-A Birthing Center	None	20%
-an Extended Care Center or Rehabilitation Center	None	20%
-a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
-Prescription Drugs	None	20%
-Blood Transfusions	None	20%
-Infusion Therapy	None	20%
-Chemotherapy	None	20%
-Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%
Maximum Out of Pocket:		$7,500

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:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

[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.

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

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to any Copayment, Cash Deductible or Coinsurance)	
-per Covered Person	$100 *
[-per Covered Family	$300] *

* The $100 and $300 limits do not apply to services from a network Practitioner. *Note to carriers: Include the asterisks and asterisked text for plans with network benefits.*

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 as follows:

Coverage	**Premium Rate**
Health Benefits	
-per Employee	$9999.99]
[-per Employee and spouse	$9999.99
-per Employee and child(ren)	$9999.99
-per Employee, spouse and child(ren)	$9999.99]

[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 avoid 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]. Each may be paid at a [Carrier'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 to [Carrier] for the time this Policy is in force.

[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 eligible Employee 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; or
e. the Employee is covered under another group health benefits plan.

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

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 following 180 days advance written notice to the Policyholder for the following reasons:
a) subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
b) subject to the statutory notification requirements, [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.

[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 Employees are covered by this Policy. If an eligible 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; or
    2. the Employee is covered under any other 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; or
    5. The Employee is covered under another group health benefits plan,
    [Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements;

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

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. [[Carrier] may honor such direction at [Carrier's] option.] [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.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

a) agrees to participate in the trust, and
b) applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed
The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[Note: This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

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.

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.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

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 this 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.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered

under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights.) 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.

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, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner , and]
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] attains age 26;
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 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.

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. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. 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.

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

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.

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 Pharmacopoeia 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 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.

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) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [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.

[**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.

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;
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 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.

[**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.

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 and are covered by this Policy.

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

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [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 "Planholder" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased this 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 "Employee Retirement Income Security Act of 1974" (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.

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

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.

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.

Pre-Existing Condition means for a Covered Person who is age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition

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

Preventive Care means:
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; 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.

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.

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, foot orthotics and supportive devices for the foot.

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

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

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

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means, 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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.

Substance Abuse means abuse of or addiction to drugs or alcohol.

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 pre-operative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as Surgery.

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

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.

[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 eligible to be covered for benefits under the terms of the Group Health Plan.]

[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.]

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

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 are subject to this Policy's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6 months] of continuous Full-Time service with the Policyholder.]

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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 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. Coverage is scheduled to start on the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.

[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

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights.) and
   - 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;

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

An Employee's "Dependent child" includes:
Your "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children
c) the child of his or her civil union partner , [and]
d) [the child of his or her domestic partner , and]
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.

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, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees age 19 or older are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form; or
b) the date the Employee becomes insured for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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 am [on the last day of the calendar month] [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.

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.
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.
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.

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 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.

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 issued as POS.]

[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 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 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 Cash Deductible
Each Calendar 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 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.

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar 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 Year. What [Carrier] pays is based on all the terms of this Policy.]

[Per Covered Family
The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. 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.]

[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 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 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 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 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 Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits and Services** 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 Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Employer'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 Year in which this Policy starts or during the 90days 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; or
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.

Charges while Hospitalized
[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a) Hospital room and board
b) Routine Nursing Care
c) Prescription Drugs
d) Blood transfusions
e) Infusion Therapy
f) Chemotherapy
g) Radiation Therapy
h) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

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.

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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of care described above, the mother may elect to participate in a home care program provided by [Carrier].]
[Carrier] will also cover Outpatient Hospital services.

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.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Copayment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Copayment per Calendar Year.

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.]

Testing Charges
[Carrier] covers 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.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges
Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. 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, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a) 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.

[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.

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.

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 which are incurred while the Covered Person is an Inpatient in a Hospital.

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.

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.

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, when Hospice Care can take the place of Inpatient Hospital Care, [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. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"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.

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 prenatal 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
[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and [DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under this Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Policy, [Carrier] will provide credit as follows. [Standard method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under this Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

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 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 the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a) *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
b) *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.

[Carrier covers the therapy Services listed below but only when provided on an Inpatient basis.

c) *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
d) *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
e) *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.
f) *Speech Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, combined, is limited to 30 visits per Calendar Year.

g) *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h) *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

i) *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.

Preventive Care
[Carrier] covers charges Preventive Care, as defined. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person [, $300 per Covered Family].

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $100 and $300 limits do not apply to services from a Network Practitioner.

[[Carrier] covers FDA-approved contraceptive services for female Covered Persons as part of the Preventive Care coverage.]

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.

[Transplant Benefits
[Carrier] covers charges for:

a) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
b) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

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 these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment 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 a 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 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. 11:24A-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 admission 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 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, [[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 Year and Per Lifetime 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:

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.

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.

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.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***dose-intensive chemotherapy***[, except as otherwise stated in this Policy.]

Durable Medical Equipment

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.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Policy.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of 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.***

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.

Care and treatment for ***Mental Illness and Substance Abuse.***

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.***

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 an 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.

Podiatric care

Practitioner visits, except as otherwise stated in this Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis, except as provided in the Preventive Care section of this Policy.

Services or supplies that are not furnished by an eligible **Provider.**

Services related to ***Private Duty Nursing*** care, except as provided in the Home Health Care section of this Policy.

Prosthetic Devices

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; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

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, eligibility for full-time student status, provided the Covered person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning 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.**

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.

Therapeutic Manipulation.

Transplants [, except as otherwise stated 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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products and except as provided in the Food Products for Inherited Metabolic Diseases provision.

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.
d) 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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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.

Maximum benefit
The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

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 Year, or portion of a Calendar 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 "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. 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO 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 will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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 XVI 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 and Services** 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 AND SERVICES** 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.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).

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 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

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [September 23, 2010]

POLICY ANNIVERSARIES: [September 23rd of each year beginning in 2011.]

PREMIUM DUE DATES: [Effective Date, and the 23rd day of the month beginning with October 2011.]

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
["DC" THIS SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS INDEMNITY PLAN AND THE HMO PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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

POLICY INDEX

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under the HMO Plan)

Copayment	
For Preventive Care:	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	[$50], credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the HMO Plan's Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under this Indemnity Plan)

Cash Deductible (calendar year, all cause)	[$2,500] per person except as stated for Preventive Care [$5,000 per family] [Note: Must be individually satisfied by 2 separate [Members]] [$7,500]

Emergency Room Copayment (waived if admitted within 24 hours)	**[$50]**
Coinsurance	
For Preventive Care:	0%
For all other Covered Charges	**[30%, 20%]**
Network Maximum Out of Pocket	**$7,500**
MAXIMUM LIFETIME BENEFITS	Unlimited,

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 Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the Carrier, $50, $75, or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
For all other Covered Charges	40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.

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

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum. [Note: Must be individually satisfied by 2 separate Covered Persons]]
	[Dollar amount equal to three times the per Covered Person maximum]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]]
	[Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.
The **Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum. [**Note:** Must be individually satisfied by 2 separate Covered Persons]]
	[Dollar amount equal to three times the per Covered Person maximum]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]]
	[Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.
The **Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum. [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount equal to three times the per Covered Person maximum]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for prescription Drugs].

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 Year Cash Deductible

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

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.
The **Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	$1650
[Per Covered Family per Calendar Year	[$3,300 [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [$4,950]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

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] **Note**: Must be individually satisfied by 2 separate Covered Persons

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or 100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts [for services and supplies of 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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**
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[$5, $10, $15, $20, $30, $40 or $50]

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

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] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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, 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. 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 covered services and supplies [other than prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Non-Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[$5, $10, $15, $20, $30, $40 or $50]

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits

Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
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 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. 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 Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [Note: Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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**
For all other treatment, services and supplies given by a **Network** Provider	
Physician Visits	[$5, $10, $15, $20, $30, $40 or $50]
Hospital Confinement	[$300 per day, up to $1500 per confinement, $3,000 per Calendar 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 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	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Calendar 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] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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, 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	20%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE INDEMNITY 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:

CLASS(ES)
[All eligible employees]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
For all other treatment, services and supplies given by a **Network** Provider	
Primary Care Physician Visits	[$5, $10, $15, $20, $30]
All other Physician Visits	[$10, $30, $40 or $50]
Maternity Visits (Pre-natal care)	[$25, $30, $49, $50] for initial visit only
Hospital Confinement	[$300 per day, up to $1500 per confinement, $3,000 per Calendar Year]

Calendar 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	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	20%[, **except as stated below]**
[**Exception**: The Coinsurance for Prescription Drugs is:	20% - $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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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]
- Fertility Services
- Nutritional Counseling
- [Certain Prescription Drugs]

[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.

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

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) 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 Year (combined benefits) 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 Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar 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 Year in which the Dependent child attains age 1	$750 per Covered Person]*
• for all [other] Covered Persons	$500 per Covered Person*
Charges for hearing aids for a Covered Person age 15 or younger	$1,000 per hearing impaired ear per 24-month period

* 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.

[Plans B, C, D, E (Continued)]

Per Lifetime Maximum Benefit (for all Illnesses and Injuries) Unlimited

["DC" THIS INDEMNITY PLAN AND THE ASSOCIATED HMO PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THIS INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THE HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THE HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THIS INDEMNITY PLAN.]

[FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THE HMO PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE COVERED PERSON RECEIVES UNDER THE HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THIS INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THIS INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE COVERED PERSON RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THE HMO PLAN AND THE COVERED CHARGES SECTION OF THIS INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

PREMIUM RATES

[The initial monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	**Premium Rate**
Health Benefits	
- per Employee	$9999.99]
[- per Employee and spouse	$9999.99
- per Employee and child(ren)	$9999.99
- per Employee, spouse and child(ren)	$9999.99]

[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.

["DC" Note: The premium rates set forth above are for coverage under this Indemnity Plan only. Refer to the HMO Plan issued in conjunction with this Indemnity Plan for information on the premium rates applicable to the HMO Plan coverage.]

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; ["DC" and]
[d.] the individual applications, if any, of the persons covered[.] ["DC" and
e. the associated HMO Plan.]

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]. Each may be paid at a [Carrier'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 to [Carrier] for the time this Policy is in force.

[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 eligible Employee 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; or
e. the Employee is covered under another group health benefits plan.

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.

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 180 days advance written notice to the Policyholder for the following reasons:

a) subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
b) subject to the statutory notification requirements, [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.

[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 Employees are covered by this Policy. If an eligible 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; or
    5. The Employee is covered under another group health benefits plan,

    [Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements;
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

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.

[PLANHOLDERS
The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder
An Employer must submit a signed application in which he:
a. agrees to participate in the trust; and
b. applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder
The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder
The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed
The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements. It is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

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.

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.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and

automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights. .) and
- the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

Dependent child who is under age 26.

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) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner, and] [
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 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.

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. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. 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.

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

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.

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 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.

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.

["DC" HMO Plan means the Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier] in conjunction with this Indemnity Plan.]

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) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [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.

["DC" Indemnity Plan means the Small Employer Health Benefits Policy issued by [Carrier].]

[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.

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.

[**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.

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.

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.

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.

["DC" Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] providers under an Indemnity Plan. 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 Physician) or those of a [Non-Network] provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

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.

Pre-Existing Condition means ,for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

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

Preventive Care. 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; 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

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.

[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, 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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.

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.

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.

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.

[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 eligible to be covered for benefits under the terms of the Group Health Plan.]

[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 ["DC"
a)] the Employees are [Actively at Work] Full-Time Employees[.] ["DC" and;
b) the Employees enroll under the associated HMO Plan.]
[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.]

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

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 are subject to this Policy's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6 months] of continuous Full-Time service with the Policyholder.]

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.

[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.
["DC" e) [the date] an Employee ceases to be covered under the associated HMO Plan.]

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights..)
   - 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

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) 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.]

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. ["DC" Only eligible Dependents who the Employee includes for coverage under the associated HMO Plan may be enrolled under this Indemnity Plan.] [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.

Late Enrollees age 19 or older are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.
; or
b) the date the Employee becomes insured for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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.
["DC" g) the date the Dependent ceases to be covered under the associated HMO Plan.]

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.

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.
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.
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.

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

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.

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.

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.]

[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 Cash Deductible
[Each Calendar 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 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 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 Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before [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 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.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar 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 Year. What [Carrier] pays is based on all the terms of this 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 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 Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once [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 Year.

What [Carrier] pays is based on all the terms of this Policy.]

[Per Covered Family
The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]]

[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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar 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 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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]]

[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 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 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 Year.]]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. 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 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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by [Carrier].]

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges up to the daily room and board limit for a Special care Unit shown in the Schedule.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's **Emergency Room 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.

[PLANS B,C,D,E]

Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the 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.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

[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.
["DC" NOTE: ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

Home Health Care Charges
Subject to [Carrier's] Pre-Approval, when 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.

[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. .

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.

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.]
["DC" NOTE: ANY NEWBORN CHILD SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

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.

[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. 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 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 PPO or a POS)

[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)

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. 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

[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.]

Dental Care and Treatment
[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.

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, [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, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.
Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
[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.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier]

waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under this Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Policy, [Carrier] will provide credit as follows. [Standard method][[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [[Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits,][Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under this Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. . [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Policyholder has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

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 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 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 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.

["DC" NOTE: ANY THERAPY SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPY BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Covered Person is under 21 years of age, 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.

["DC" NOTE: ANY AUTISM AND OTHER DEVELOPMENTAL DISABILITIES SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE AUTISM AND OTHER DEVELOPMENTAL DISABILITIES BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Policy.

[Carrier] will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under 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 Year to:
a) $750 per Covered Person for a Dependent child from birth until the end of the Calendar 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 do not apply to services from a Network Practitioner.
["DC" NOTE: ANY PREVENTIVE CARE SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE UNDER THE INDEMNITY PLAN.]

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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

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. Such vision examination is not covered under this Policy.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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, breast 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 Year and Per Lifetime 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:

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.

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.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of 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.

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***.

["DC" Services or supplies provided under the associated ***HMO Plan.***]

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.

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, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by [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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products 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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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 ["DC" ,where this Indemnity Plan is issued in conjunction with an HMO Plan. This Effect of Interaction with a Health Maintenance Organization Plan provision does **not** apply to Employees and their Dependents who are HMO members due to coverage under this Indemnity Plan and the associated HMO Plan.] If the Employer does ["DC" offer HMO membership under an HMO plan *other than* the associated HMO Plan], 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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Covered Person]. The [Covered Person] is liable only for the applicable deductible, coinsurance or copayment. If the [Covered Person] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

<u>Primary Plan is an AC Plan and Secondary Plan is an AC Plan</u>
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.

<u>Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan</u>
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.

<u>Primary Plan is an AC Plan and Secondary Plan is Fee Schedule Plan</u>
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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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).

EXHIBIT G

[Carrier] HMO PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)CONTRACT

CONTRACTHOLDER:	[ABC Company]
GROUP CONTRACT NUMBER [G-12345]	**GOVERNING JURISDICTION** NEW JERSEY
EFFECTIVE DATE OF CONTRACT:	[September 23, 2010]
CONTRACT ANNIVERSARIES:	[September 23rd of each year, beginning in 2011]
PREMIUM DUE DATES:	[Effective Date, and the 23rd day of the month beginning with October 2010.]
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]

["DC" THIS SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS HMO PLAN AND THE INDEMNITY PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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

TABLE OF CONTENTS

SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:
Covered Employee Only ..... $]

[Covered Employee and Spouse..... $

Covered Employee and Child(ren)..... $

Covered Employee and Family ..... $
(including Covered Employee, spouse and one or more eligible dependents)]

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."

["DC" Note: The premium rates set forth above are for coverage under this HMO Plan only. Refer to the Indemnity Plan issued in conjunction with this HMO Plan, for information on the premium rates applicable to the Indemnity Plan coverage.]

This Contract's classifications, and the coverages and amounts which apply to each class are shown below:

CLASS(ES)
[All eligible employees]

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under this HMO Plan)	
Copayment	
For Preventive Care	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under the Indemnity Plan)	
Cash Deductible (calendar year, all cause)	[$2,500] per person except as stated for Preventive Care [$5,000 per family] [Note: Must be individually satisfied by 2 separate [Members]]
Emergency Room Copayment (waived if admitted within 24 hours)	[$50]
Coinsurance	
For Preventive Care	NONE
For all other Covered Charges	[30%, 20%]
Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS Unlimited,
SCHEDULE OF SERVICES AND SUPPLIES [Using Copayment]

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS[/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT	[$75, $100, $150, $200, $300, $400, $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [$750, $1000, $1,500, $2,500, $3,000, $4,000, $5,000]/Calendar Year. Unlimited days.
OUTPATIENT	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[$5, $10, $15, $20, $30, $40, $50] 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)
SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit
HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.

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

THERAPEUTIC MANIPULATION	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN **For services other than Preventive Care [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)**	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
PRIMARY CARE SERVICES **other than Preventive Care**	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
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	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
SPECIALIST SERVICES	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
SKILLED NURSING FACILITY/EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES Speech and Cognitive Therapy (Combined), maximum30 visits per Calendar Year See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
Physical and Occupational Therapy (Combined) maximum 30 visits per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per Calendar Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits per Calendar Year
DIAGNOSTIC SERVICES **INPATIENT** **(OUTPATIENT)**	$0 Copayment [$5, $10, $15, $20, $30, $40, $50] Copayment/visit
HEARING AIDS for Members age 15 or younger	[$5, $10, $15, $20, $30, $40, $50] Copayment with coverage limited to $1,000 per hearing impaired ear per 24-month period
SCHEDULE OF SERVICES AND SUPPLIES	[Example Using Deductible, Coinsurance]

The services or supplies covered under this Contract are subject to the Copayments Deductible and Coinsurance set forth below and are determined per Calendar Year per [Member], unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT	
For Preventive Care	NONE
For all other Primary Care Physician Visits	[$5, $10, $15, $20, $30, $40, $50] per visit
Maternity (pre-natal care)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment/initial visit.
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER CALENDAR YEAR	
•For Primary Care Physician Visits including Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•for all other Covered Services and Supplies	
•Per Covered Person	[$250 to $2,500]

•[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%
For all 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 [at the option of the carrier, $50, $75, $100] 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.

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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.

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

•Per Member per Calendar Year	[An amount not to exceed $7,500]
•[Per Member per Calendar Year	[Dollar amount equal to two times the per Member Maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges or with charges for Prescription Drugs.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, 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 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 Year
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per Calendar Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits per Calendar Year
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval
Hearing Aids for Members age 15 or younger	[$5, $10, $15, $20, $30, $40, $50] Copayment with coverage limited to $1,000 per hearing impaired ear per 24-month period

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" FOR A LIST OF THE SERVICES AND SUPPLIES FOR WHICH A [MEMBER] IS NOT ELIGIBLE FOR COVERAGE UNDER THIS CONTRACT.

["DC" THIS HMO PLAN AND THE ASSOCIATED INDEMNITY PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THE INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THIS HMO PLAN. SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THIS HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THE INDEMNITY PLAN.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THIS CONTRACT WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE [MEMBER] RECEIVES UNDER THIS HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THE INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THE INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THIS HMO PLAN AND THE COVERED CHARGES SECTION OF THE INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

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.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

[CASH DEDUCTIBLE. A fixed dollar amount that a Member must pay before [Carrier] provides the Member with coverage for Covered Services or Supplies.]

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a [Member]. Coinsurance does not include Copayments [or Cash Deductible].]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and [Carrier].

CONTRACTHOLDER. 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.

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help [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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights.) 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; and

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, 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.

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. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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.

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 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.

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 CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] Providers provide Covered Services and Supplies to [Members].]

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

[**"DC" HMO PLAN**. The Small Group Health Maintenance Organization Contract issued by [Carrier].]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

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

ILLNESS or ILL. A sickness or disease suffered by a [Member] or a description of a [Member] suffering from a sickness or a disease. Illness includes Mental Illness.

[**"DC" INDEMNITY PLAN.** The Small Employer Health Benefits Policy issued by [Carrier] in conjunction with this HMO Plan.]

[**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.

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 Us [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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.
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.

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.

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.

["DC" POINT OF SERVICE PLAN. Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] Providers under an Indemnity Plan. 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 Physician) or those of an [Non-Network] Provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

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.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition. See the **Non-Covered Services and Supplies** section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.]

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 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; 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 PHYSICIAN (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member]'s Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

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.

PUBLIC HEALTH PLAN. 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.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that 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. 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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)].

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.

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.

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

[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.]

[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 reside in the Service Area will be eligible if ["DC"
a)] the Employees are [Actively at Work] Full-Time Employees[.] ["DC" and;
b) the Employees enroll under the associated Indemnity Plan.]
[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.]

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility**.

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 are subject to this Contract's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Contractholder.]

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:

a) the Employee was employed by the Contractholder on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date We or Our authorized representative or agent receive the signed enrollment form.

[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 moves his or her permanent residence outside the Service Area.]
["DC" f) [the date] an Employee ceases to be insured under the associated Indemnity Plan.]

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners not civil union partners have COBRA rights.) 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; and

[Exception: Any dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children and Step-Children
An Employee's " Dependent children" include the Employee's legally adopted children, his or her step-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. ["DC" Only eligible Dependents who the Employee includes for coverage under the associated Indemnity Plan may be enrolled under this HMO Plan.] [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.

Late Enrollees age 19 or older are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date We or Our authorized representative or agent receives the signed enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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.]
["DC" h) the date the Dependent ceases to be insured under the associated Indemnity Plan.]]

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 PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services ["DC" under this HMO Plan] only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

["DC" Note: Under the terms of the associated Indemnity Plan, there is no requirement that the Member contact a Primary Care Physician to access services or supplies, but all benefits are subject to the terms and conditions of the associated Indemnity Plan.]

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a [Member's] treatment for [Mental Illness or, Substance Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Physician from Our [Physician or Practitioners] Directory].

[For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's] coverage. If the [Member] who misuses the card is the 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 Physician.

Except in the case of an Emergency, a [Member] will not be eligible for any services ["DC" under this HMO Plan] provided by anyone other than a [Member's] Primary Care Physician (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences ["DC" under this HMO Plan]. 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 Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

LIMITATION ON SERVICES
Except in cases of Emergency, services ["DC" under this HMO Plan] are available only from Network Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a [Member] from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT
[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service"] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member], the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 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 Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

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 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

["DC" Under this HMO Plan,] [Members] are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable copayments [Cash Deductible,] [or Coinsurance] as stated in the applicable Schedule of Services and Supplies and subject to the terms, conditions and limitations of this Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior written Referral by a [Member]'s Primary Care Physician [or Health Center] [or the Care Manager]:
1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Home visits** by a [Member]'s Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member]'s employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a [Member]'s Primary Care Physician and Pre-Approved by Us.

7. **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. 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 Physician and arranged through Us.
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.
    [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. 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.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases:** We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:
a) 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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the 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 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. 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.]

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior written Referral by a [Member]'s Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:
1. Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Network Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

a) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

2. Private accommodations [will be provided only when Pre-Approved by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services

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.

["DC" NOTE: ANY NURSING CARE BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE NURSING CARE SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(j) **Hospice Care** if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member]'s Primary Care Physician. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

I(k) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a [Member] who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

(l) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.
(m) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

["DC" NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(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.]

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

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.

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.

Services or supplies for or in connection with:
a) except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of 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 intrafallopian 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.

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***: 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.

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.

["DC" [Services or supplies for which benefits are paid under the associated **Indemnity Plan.]**

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.**

17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

21. The following transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestines.
22. Allogeneic bone marrow transplants.
[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]
[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]
25. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR 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 Physician [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 ["DC" under this HMO Plan] without prior written Referral by a [Member]'s Primary Care Physician in the event of an Emergency as Determined by Us.

1. A [Member]'s Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:
a. Our review Determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
c. We and the [Member]'s Primary Care Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event a [Member] is Hospitalized in a Non-Network Facility, coverage will only be provided until the [Member] is medically able to travel or to be transported to a Network Facility. If the [Member] elects to continue treatment with Non-Network Providers, We shall have no responsibility for payment beyond the date the [Member] is Determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written Referral to a Network Provider.

4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the [Member] shall be responsible for payment.

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 Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
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 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 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.

["DC" NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPY SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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.

["DC" NOTE: ANY AUTISM AND OTHER DEVELOPMENTAL DISABILITIES SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE AUTISM AND OTHER DEVELOPMENTAL DISABILITIES BENEFITS AVAILABLE UNDER THIS HMO PLAN.]

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Physician. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in this Contract for food and food products for inherited metabolic diseases.

Services provided by a **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations:
The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Contractholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.
We do not pay benefits for charges for Pre-Existing Conditions for Members age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits,] We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Contractholder has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.]

Any service provided without prior written Referral by the [Member]'s **Primary Care Physician,** except as specified in this Contract.

Services related to **Private Duty Nursing**, except as provided under the Home Health Care section of this Contract.

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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products except as provided in the Nutritional Counseling and Food and Food Products for Inherited Metabolic Diseases items of this Contract.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

COORDINATION OF BENEFITS AND SERVICES

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 Year, or portion of a Calendar 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 "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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under this Contract when services are provided as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a [Member] as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

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 eligible Employee is not covered by this Contract because:
a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
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; or
e. the Employee is covered under another group health benefits plan.

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

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. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force.

[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 180 days advance written notice to the Contractholder for the following reasons:
a) subject to the statutory notification requirements, We cease to do business in the 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.

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 Employees are covered by this Contract. If an eligible 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; or
    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; or
    5. The Employee is covered under another group health benefits plan,

    We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;
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

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; ["DC" and]
[d)] the individual applications, if any, of all [Members][.] ["DC" and
e) the associated Indemnity plan.]

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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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).

EXHIBIT H

CARD/MAIL/PRE-APPROVAL/PREFERRED

RIDER FOR PRESCRIPTION DRUG [INSURANCE]

[Policy]holder:
Group Policy No:
Effective Date:

The Prescription Drug Coverage under this Rider [replaces] [supplements] the Prescription Drug coverage specified under the [Policy] to which this Rider is attached when Prescription Drugs are obtained from [either] a [Participating Pharmacy] [or a] [Participating Mail Order Pharmacy].

[Subject to [Carrier] Pre-Approval of certain Prescription Drugs,] [Carrier] cover[s] Prescription Drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only cover[s] 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:
   - 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 Prescription Drugs also includes Medically Necessary and Appropriate services associated with the administration of the Prescription 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 otherwise stated above.

And [Carrier] exclude[s] drugs that can be bought without a prescription, except for insulin, even if a Practitioner orders them.

DEFINITIONS

Brand Name Drug means:

a) a Prescription Drug as determined by the Food and Drug Administration; and
b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drug means:

a) a therapeutically equivalent Prescription Drug, as determined by the Food and Drug Administration;
b) a drug which is used unless the Practitioner prescribes a Brand Name Drug; and
c) a drug which is identical to the Brand Name Drug in strength or concentration, dosage form and route of administration.

[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.

[Non-Preferred Drug means a Prescription Drug that is not included on [Carrier's] list of Preferred Drugs.]

[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 [ABC] or with whom [ABC] has signed a pharmacy service agreement.

[**Preferred Drug** means a Prescription Drug that:
a) has been designated as such by either [Carrier's] pharmacy and therapeutics committee, or by a third party with which [Carrier] contract[s], as a Preferred Drug;
b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and
c) is included on 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 Drug means:
a) Legend Drugs
b) compound medications of which at least one ingredient is a Legend Drug;
c) insulin; and
d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

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

[PREAPPROVAL REQUIREMENT
[Carrier] [has/have] identified certain Prescription Drugs for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. [Carrier] 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 [Covered Person] brings a prescription for a Prescription Drug for which [Carrier] require[s] 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] give[s] 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] do[es] 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 a denial by following the Appeals Procedure process set forth in the [Policy].]

COPAYMENT

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:

[• for Generic Drugs	$[5.00 – $15] per up to a 30 day supply
• for Brand Name Drugs	$[10.00 – $25] per up to a 30-day supply

[The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

• for Generic Drugs	[NONE – $25] per up to a 90-day supply
• for Brand Name Drugs	[$5.00 – $50] per up to a 90-day supply]]

*[Note to carriers – Use the above copayment section if the rider does **not** include preferred/non-preferred provisions.]*

[• for Generic Preferred Drugs	[$5.00 – $20] per up to a 30 day supply
• for Brand Name Preferred Drugs	[$15.00 – $25] per up to a 30 day supply
• for Brand Name Non-Preferred Drugs	[$25.00 – $40]] per up to a 30 day supply

[The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

• for Generic Preferred Drugs	[NONE – $25] per up to a 90-day supply
• for Brand Name Preferred Drugs	[$5.00 – $30] per up to a 90-day supply]
• for Brand Name Non-Preferred Preferred Drugs	[$5.00 – $50] per up to a 90-day supply]

[Note to carriers – Use the above copayment section if the rider does include preferred/non-preferred provisions.]

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment 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 at the Department of Health and Senior Services.]

COVERED DRUGS

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.

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.

[AUDIT PROCEDURES

[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 rider, include your specific audit procedures as an additional paragraph.]

OTHER CHARGES

[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.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a) Charges to administer a Prescription Drug.
b) Charges for:
d) immunization agents
e) biological sera
f) blood or blood plasma.
c) Charges for a Prescription Drug which is:

g) labeled "Caution - limited by Federal Law to Investigational use"; or
h) experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g) 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:
i) a Hospital
j) a rest home
k) a sanitarium
l) an Extended Care Facility
m) a Hospice
n) a Substance Abuse Center
o) an alcohol abuse or mental health center
p) a convalescent home
q) a nursing home
or similar institution.
h) Charges for:
r) therapeutic devices or appliances
s) hypodermic needles
t) syringes, except insulin syringes
u) support garments
and other non-medical substances, regardless of their intended use.
i) Charges for vitamins, except Legend Drug vitamins.
j) Charges for drugs for the management of nicotine dependence.
k) Charges for topical dental fluorides.
l) Charges for any drug used in connection with baldness.
m) 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 [Covered Person] taking part in the commission of a felony.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
o) Charges for drugs dispensed to a [Covered Person] while on active duty in any armed force.
p) 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.
q) Charges for drugs covered under the [Policy] to which this Rider is attached which are covered under the Home Health Care or Hospice Care sections of the [Policy.]
r) 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.

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

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

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 27 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 30 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets for the HMO plan, which appears later in this document, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. 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 Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
5. If a Carrier elects to provide for a family deductible and family maximum out of pocket allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and maximum out of pocket must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note**: ALL plans issued by a Carrier MUST include the same option.
6. 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.
7. The list of services and supplies for which pre-approval is required includes two new 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 6 months 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 3 months. 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 PPO and POS 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. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.
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. 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. ($5, $10, $15, $20, $30, $40 or $50)
    b. Include the specific page of text describing either the PPO or the POS mechanism, with specification of the name of the network or provider organization.
28. Carriers that intend to use the standard indemnity forms as the non-network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Only Plans C and D may be used to provide the non-network benefits. Plans C and D must be issued as pure indemnity plans. That is, they may **not** be plans issued through or in conjunction with a Selective Contracting Arrangement.

Throughout the text, variable text which begins with "DC" appears. **All** of the variable text which is designated as "DC" text **must** be included when indemnity plans C or D are used as the non-network portion of a Dual Contract POS plan. **All** of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

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) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.
g) 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.

Note: Explicit guidance for the issuance of a Dual Contract POS product is set forth in item 18 below. Carriers that issue a Dual Contract POS product should refer to the above explanations for Plans C and D for guidance on the variable text that appears in the indemnity form that would be issued in conjunction with the HMO form to produce the Dual Contract POS plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract and Evidence of Coverage forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. Co-Payments may be elected by the 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. 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.
6. 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.
7. 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.
8. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
9. OB/GYNs can be considered Primary Care Physicians.
10. Eligible class references can be removed.
11. 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 6 months 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 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
12. 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.
13. 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.
14. 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.
15. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
16. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
34. 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. Carriers that intend to use the standard indemnity forms as the network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Throughout the text, variable text which begins with "DC" appears. *All* of the variable text which is designated as "DC" text *must* be included when the HMO plan is used as the network portion of a Dual Contract POS plan. *All* of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

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 the use of a care manager, health center, and 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.

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. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
9. Carriers that do not use a "Care Manager" should omit the definition of Care Manager, and omit the term as it appears throughout the text.
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. Carriers that do not use "Health Care Centers or Health Centers" should omit the definition of Health Care Centers or Health Centers, and omit the terms as they appear throughout the text.
12. 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 six months, as set forth in N.J.A.C. 11:21-7.9(c). The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
13. 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.)

14. 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.
15. Carriers that do not have a home care program that satisfies the requirements of the New Jersey "48 hour maternity" statute, (P.L.1995, c.138) should omit the reference to such program in the text of the Inpatient Hospice, Hospital, Rehabilitation Center & Skilled Nursing benefits section of the plan.
16. 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.
17. Carriers may elect to calculate the non-network family deductible as two times the individual deductible, calculated on a per individual basis, or as three times the individual deductible, calculated on an aggregate basis. The Schedule and the Non-Network Benefit provision must reflect the selected calculation. *Note*: All plans issued by a Carrier must reflect the same election.
18. 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.
19. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
20. Carriers that wish to apply pre-approval requirements to non-network prescription drug coverage should include the variable pre-approval text.
21. The Pre-Existing Conditions exclusion may be omitted.
22. 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.
23. 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.
24. The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
25. 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.
26. 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.
27. The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
28. The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.

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.

Prescription Drug Rider
(Appendix Exhibit H)

All text which is enclosed in brackets [] is variable.

This rider is designed to be used with both HMO and non-HMO based plans. Policyholder can be changed to read Contractholder, as appropriate. Covered person can be changed to read Member, as appropriate.

Some areas of variability are self-explanatory. Examples include: [Carrier] and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the copayment text.

The rider can be used to provide a card only benefit, a mail only benefit, a card/mail benefit. It can be used to require pre-approval for certain drugs. It can also be used to specify different levels of benefits for preferred v. non-preferred drugs.

Employer Application
(Appendix Exhibit N)

1. Contractholder or Planholder and Contract or Plan, as appropriate.
2. The terms Policyholder and Policy may be replaced with terms insurance and insured may be replaced with coverage and covered, as appropriate.
3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.
4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.
5. Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.
6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.

7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.
8. If a carrier elects to allow applications to be submitted electronically, the signature lines on the application may be omitted. However, New Jersey's Insurance Code does not specifically address the use of electronic mediums for the application process. It is the carrier's responsibility to comply with all existing New Jersey statutes, regulations and pertinent case law dealing with general contract law or electronic signatures to determine acceptability of any electronic application process. The carrier is cautioned, however, that the use of such mediums may result in the waiving of or limitations in the Carrier's right to contest coverage or limit benefits for pre-existing conditions. The existence of variable material on the standard application form should not be construed as acceptability of the electronic process.

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).

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

[Carrier]

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS [POLICY]

Please print or type [Policy] number ([Carrier] Use Only)

New [Policy] Change in [Policy]
Requested Effective Date _____
Note: The Effective Date will be on or after the date [Carrier] approves the application.

SECTION I: [POLICY]HOLDER INFORMATION

1. Policyholder (full legal name of company): _____
2. Tax Identification Number: _____
3. Main Address: _____
   Street City State Zip
   Mailing Address: _____
   Street City State Zip
   Telephone: ( )_____ Facsimile: ( )_____
4. Name of Correspondent: _____
5. Type of organization: Corporation Partnership
   Proprietorship Other (explain): _____
6. Nature of business (specify): _____
   SIC Code _____
7. Number of eligible employees in your company: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: Employees Only Employees & Dependents
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246?
    Yes No
    If yes, should the plan provide coverage for coverage of children of a covered domestic partner?
    Yes No
11. Is the employer subject to the requirements of COBRA? Yes No
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age?
    Yes No due to disability? Yes No
13. Waiting period before employees become insured: (may not exceed 6 months)
    Present employees:_____ New or Rehired Employees:_____
14. What percentage of the premium will the employer pay?_____
15. Deposit $_____

Premium Paid: Monthly [Quarterly] [Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible employees in this company	No eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS

Plan: A B C D E HMO HMO-POS Dual Contract POS

Deductible -Carrier to identify available options

High Deductible Options: $ $

Co-Payment (Options for HMO Plans Only): $5 $10 $15 $20 $30 $40 $50

Managed Care Delivery System: PPO POS None

PRESCRIPTION DRUG BENEFITS
Program Type: [Carrier to identify available options]
NON-STANDARD OPTIONAL BENEFIT RIDERS

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   •now in force and to be continued? Yes No
   •currently being applied for? Yes No
   If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)
   _____
2. Name of present or prior group carrier _____
   Effective date of prior coverage: _____
   Cancellation/termination date: _____
   Is the coverage applied for in this application replacing other group insurance?
   Yes No
   If "Yes" give reason _____
   Plan being replaced: A B C D E HMO HMO-POS
   Dual Contract POS Other: _____
3. Has your firm been uninsured for 3 or more months prior to application?
   Yes No
4. What forms of insurance are now or were in force?
   Health Benefits Prescription Drugs (attach copies of Booklet / Certificate and most recent Billing Statement)
5. Are extended benefits provided in case of termination of health benefits?
   Yes No
6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?
   Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability /Other	Continuation Dates Start End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:
   a) Are any employees or dependents presently incapacitated?
   Yes No
   b) Are any dependent children incapable of self-support due to a physical or mental disability?
   Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____
_____
_____
_____
_____

8. Does the employer participate in an arrangement with a Professional Employer Organization?
   Yes No (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organizations.)

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]

SECTION V: SIGNATURE

[It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

[_____ _____
Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor]

[_____]
Witness to Signature]

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

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).

EXHIBIT O

EMPLOYER CERTIFICATION

"Carrier's Logo"

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continuees	Other

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other group Health Benefits Plan through a different employer _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage: Medicare, Medicaid, or NJ FamilyCare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, 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 two, but not more than 50, eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

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 Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to "Carrier" is true and complete.** I understand that if the above information is not complete or is not provided to "Carrier" in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

_____

Signature of Officer, Partner or Owner Title Date

_____

Print Name of Officer, Partner or Proprietor

_____ _____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey as defined above.**

_____

Signature of Officer, Partner or Proprietor Title Date

_____

Print Name of Officer, Partner or Proprietor

_____ _____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

a employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U. Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)	Gender	Date of Birth
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

*If additional space is needed, attach a separate sheet.

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).

EXHIBIT P

(RESERVED)

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

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[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:	10-23-10]

[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

SCHEDULE OF INSURANCE PLAN A

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:

•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges -per Covered Person	$250

[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]] [$750]

Hospital Confinement Copayment

-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

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 Coinsurance Cap 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	None
•for Facility charges made by:	
-a Hospital	20%
-an Ambulatory Surgical Center	20%
-a Birthing Center	20%
-an Extended Care Center or Rehabilitation Center	20%
-a Hospice	20%
•for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
-Prescription Drugs	20%
-Blood Transfusions	20%
-Infusion Therapy	20%
-Chemotherapy	20%
-Radiation Therapy	20%
•for all other Covered Charges	50%

Maximum Out of Pocket per Covered Person per each Calendar Year $7,750

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 accommodation, [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:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

[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.

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO with common Deductible and Maximum Out of Pocket

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible:

•for Hospital Confinement	None (Note: See Hospital Confinement Copayment)
•for Preventive Care	None
•for immunizations and lead screening for children	None
•for All Other Charges	
-per Covered Person	$250

[-per Covered Family	[$500] [Note: Must be individually satisfied by 2 separate Covered Persons]]
	[$750]

Hospital Confinement Copayment

-per day	$ 250
-maximum Copayment per Period of Confinement	$1,250
-maximum Copayment per Covered Person per Calendar Year	$2,500

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 Coinsured Charge Limit 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.

	If treatment, services or supplies are given by:	
	a Network Provider	**a Non-Network Provider**
The Coinsurance for the Policy is as follows:		
•for Preventive Care	None	None
•for Facility charges made by:		
-a Hospital	None	20%
-An Ambulatory Surgical Center	None	20%
-A Birthing Center	None	20%
-an Extended Care Center or Rehabilitation Center	None	20%
-a Hospice	None	20%
•for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
-Prescription Drugs	None	20%
-Blood Transfusions	None	20%
-Infusion Therapy	None	20%
-Chemotherapy	None	20%
-Radiation Therapy	None	20%
•for all other Covered Charges	70%	50%
Maximum Out of Pocket:	$7,500	

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:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

[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.

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

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to any Copayment, Cash Deductible or Coinsurance)
-per Covered Person $100*
[-per Covered Family $300]*
* The $100 and $300 limits do not apply to services from a network Practitioner. *Note to carriers: Include the asterisks and asterisked text for plans with network benefits.*

Per Lifetime Maximum Benefit (for all Illnesses and Injuries) $1,000.000

PREMIUM RATES
[The initial monthly premium rates, in U.S. dollars, for the insurance provided under the Policy are as follows:

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]. Each may be paid at a [Carrier'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 the 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 to [Carrier] for the time the Policy is in force.

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.

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 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.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

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 this entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or [a Dependent] who is insured under the Policy.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights. .) 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;

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

An Employee's "Dependent child" includes:
a) his or her legally adopted children,
b) his or her step-child, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner ,and]
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] attains age 26;
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.
f)

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 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.

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. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. 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.

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

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.

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 Pharmacopoeia 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 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.

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) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [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.

[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.

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;
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 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.

[**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.

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 and are covered by the Policy.

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

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [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 "Planholder" definition is employed, references in the Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased this 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 "Employee Retirement Income Security Act of 1974" (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.

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

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.

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.

Pre-Existing Condition means for a Covered Person who is age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition

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

Preventive Care means:
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; 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.

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

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.

[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, foot orthotics and supportive devices for the foot.

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

Schedule means the **Schedule of Insurance and Premium Rates** contained in 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, 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least eligible two Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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.

Substance Abuse means abuse of or addiction to drugs or alcohol.

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 pre-operative and post-operative care.

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 or hydro therapy or other treatment of similar nature.

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.

[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 eligible to be covered for benefits under the terms of the Group Health Plan.]

[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.]

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

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 are subject to the Policy's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6 months] of continuous Full-Time service with the Policyholder.]

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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 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 You are not Actively at Work due to a Health Status-Related Factor, and except as stated below, an][You must be [Actively at Work, and]working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. [If You are not Actively at Work on the scheduled Effective Date, and do not qualify for the Exception to the Actively at Work Requirement, [Carrier] will postpone the start of Your coverage until You return to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your 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. Coverage is scheduled to start on the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.

[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

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights..)
   - 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; and

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

Your "unmarried Dependent child" includes:
a) Your legally adopted children,
b) Your step-children, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner , and]
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.

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 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 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
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.

Late Enrollees age 19 or older are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

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 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 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 the 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 Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date the [Carrier] or [Carrier's] authorized representative or agent receive the signed enrollment form; or
b) the date the Employee becomes insured for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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 am [on the last day of the calendar month] [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.

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.
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 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.

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 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.

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 issued as POS.]

[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 Cash Deductible
Each Calendar 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 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.

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar 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 Year. What [Carrier] pays is based on all the terms of the Policy.]

[Per Covered Family
The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. 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.]

[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 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 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 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 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 Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person 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 Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Employer'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 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; or
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 Policy to find out what [Carrier] limits or excludes.

Charges while Hospitalized
[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a) Hospital room and board
b) Routine Nursing Care
c) Prescription Drugs
d) Blood transfusions
e) Infusion Therapy

f) Chemotherapy
g) Radiation Therapy
h) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

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.

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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of care described above, the mother may elect to participate in a home care program provided by [Carrier].]
[Carrier] will also cover Outpatient Hospital services.

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.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Copayment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Copayment per Calendar Year.

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.]

Testing Charges
[Carrier] covers 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.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges
Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. 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, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a) 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 the 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.

[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 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.

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 which are incurred while the Covered Person is an Inpatient in a Hospital.

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.

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.

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, when Hospice Care can take the place of Inpatient Hospital Care, [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. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"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.

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 prenatal 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
[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See the Policy's EMPLOYEE COVERAGE and [DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is under age 19 and who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, [Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

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 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 the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a) *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
b) *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.

[Carrier covers the therapy Services listed below but only when provided on an Inpatient basis.

c) *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
d) *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
e) *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.
f) *Speech Therapy* - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, combined, is limited to 30 visits per Calendar Year.

g) *Occupational Therapy* - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
h) *Physical Therapy* - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

i) *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.

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, bone density testing, screening tests and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person[, $300 per Covered Family].

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $100 and $300 limits do not apply to services from a Network Practitioner.

[[Carrier] covers FDA-approved contraceptive services for female Covered Persons as part of the Preventive Care coverage.]

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.

[Transplant Benefits
[Carrier] covers charges for:

a) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
b) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

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 these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment 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 Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading the Policy 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 a 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 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. 11:24A-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 admission 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 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, [[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 Year and Per Lifetime 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:

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.

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.

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.

Charges made by a ***dialysis center*** for dialysis services.

Care or treatment by means of ***dose-intensive chemotherapy***[, except as otherwise stated in the Policy.]

Durable Medical Equipment

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.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

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.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of 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.***

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.

Care and treatment for ***Mental Illness and Substance Abuse.***

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.***

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 an 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.

Podiatric care

Practitioner visits, except as otherwise stated in the Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis, except as provided in the Preventive Care section of this Policy.

Services or supplies that are not furnished by an eligible **Provider.**

Services related to ***Private Duty Nursing*** care, except as provided in the Home Health Care section of the Policy.

Prosthetic Devices

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; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

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, eligibility for full-time student status, provided the Covered person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning 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.**

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.

Therapeutic Manipulation.

Transplants [, except as otherwise stated 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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products and except as provided in the Food Products for Inherited Metabolic Diseases provision.

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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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 MARRIAGEOR 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.

Maximum benefit
The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Covered Person]. The [Covered Person] is liable only for the applicable deductible, coinsurance or copayment. If the [Covered Person] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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** 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 XVI 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]..

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

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.]

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).

EXHIBIT W

[Carrier] **PLANS B, C, D, E**
SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[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;	09-23-10
CALENDAR 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.]

["DC" THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS INDEMNITY PLAN AND THE HMO PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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

CERTIFICATE INDEX

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under the HMO Plan)	
Copayment	
For Preventive Care	NONE
For all other services and supplies	$15, unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the HMO Plan's Schedule of Services and Supplies for Prescription Drugs]
[NON-NETWORK] (Provided under this Indemnity Plan)	
Cash Deductible (calendar year, all cause)	$2,500 per person except as stated for Preventive Care $5,000 per family Note: Must be individually satisfied by 2 separate Members $7,500
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	
For Preventive Care	NONE
For all other Covered Charges	20%
Network Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS Unlimited,

SCHEDULE OF INSURANCE **[PLAN B]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the Carrier, $50, $75, or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
For all other Covered Charges	40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.
The **Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount equal to [$2,000 – $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered person maximum. [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

[Dollar amount equal to three times the per Covered person maximum]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF INSURANCE **[PLAN C]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.
The **Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum. [**Note:** Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount equal to three times the per Covered Person maximum]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF INSURANCE **[PLAN D]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$250 to $5,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible. [**Note**: Must be individually satisfied by 2 separate Covered Persons]] [Dollar amount which is three times the individual Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts paid [for services and supplies other than Prescription Drugs] 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 Year.

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

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered person maximum. **[Note:** Must be individually satisfied by 2 separate Covered Persons]]
	[Dollar amount equal to three times the per Covered Person maximum]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF INSURANCE **[PLAN E]**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

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

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]

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

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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%
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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 Year.

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

Per Covered Person per Calendar Year	$1650
[Per Covered Family per Calendar Year	[$3,300 **[Note:** Must be individually satisfied by 2 separate Covered Persons]] [$4,950]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year Cash Deductibles

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

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

Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

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] **Note**: Must be individually satisfied by 2 separate Covered Persons

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or 100]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.
The Non-**Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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**
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [$5, $10, $15, $20, $30, $40 or $50]

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs
Per Covered Person [$250 to $2,500]
[Per Covered Family [Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

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] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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, 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 all other services and supplies:
• if treatment, services or supplies are given by a Network Provider 10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider 30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is: 30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for the Policy is as follows:
Per Covered Person per Calendar Year [An amount not to exceed $7,500]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]
Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Non-Network Maximum Out of Pocket** for the Policy is as follows:
Per Covered Person per Calendar Year [An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year [Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

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**
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [$5, $10, $15, $20, $30, $40 or $50]

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits
Per Covered Person [$250 to $2,500]
[Per Covered Family [Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75 or $100]
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 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. 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 Year.
The **Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or charges for Prescription Drugs].

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**
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [$5, $10, $15, $20, $30, $40 or $50]
Hospital Confinement [$300 per day, up to $1500 per confinement, $3,000 per Calendar 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 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 [$250 to $2,500]
[Per Covered Family [Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Calendar 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] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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, 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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	20%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.
The Non-**Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE INDEMNITY EPO (using Plan D, with Copayment on specified services)

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment

For Preventive Care	**NONE**
For all other treatment, services and supplies given by a **Network** Provider	
Primary Care Physician Visits	[$5, $10, $15, $20, $30]
All other Physician Visits	[$10, $30, $40 or $50]

Maternity Visits (Pre-natal care)	[$25, $30, $49, $50] for initial visit only
Hospital Confinement	[$300 per day, up to $1500 per confinement, $3,000 per Calendar Year]

Calendar 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	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

Emergency Room Copayment (waived if admitted within 24 hours) [at the option of the carrier, $50, $75, $100]
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 all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	20%[, **except as stated below**]
[**Exception**: The Coinsurance for Prescription Drugs is:	20% - $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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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]
- Fertility Services
- Nutritional Counseling
- [Certain Prescription Drugs]

[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 Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) 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 Year (combined benefits) 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 Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar 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 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.

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

["DC" THIS INDEMNITY PLAN AND THE ASSOCIATED HMO PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THIS INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THE HMO PLAN SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THE HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THIS INDEMNITY PLAN.]

[FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THE HMO PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE COVERED PERSON RECEIVES UNDER THE HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THIS INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THIS INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE COVERED PERSON RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THE HMO PLAN AND THE COVERED CHARGES SECTION OF THIS INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

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]. Each may be paid at a [Carrier'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 the 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 to [Carrier] for the time the Policy is in force.

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.

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 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.

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.

Creditable Coverage means, with respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights. .) and
   - the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

Dependent child who is under age 26; and

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 services, individualized support, and other forms of assistance that are 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.

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. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. 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.

Employee's Eligibility Date means the later of:
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

Employer means [ABC Company].

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.

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 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.

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.

["DC" HMO Plan means the Small Employer Health Benefits Health Maintenance Organization Contract issued by [Carrier] in conjunction with this Indemnity Plan.]

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) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [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.

["DC" Indemnity Plan means the Small Employer Health Benefits Policy issued by [Carrier].]

[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.

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.

[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.

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.

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.

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.

["DC" Point of Service Plan (Often referred to as a POS plan) means a plan that provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] providers under an Indemnity Plan. 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 Physician) or those of a [Non-Network] provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

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.

Pre-Existing Condition means for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

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

Preventive Care. 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; 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

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.

[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, 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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.

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.

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.

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.

[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 eligible to be covered for benefits under the terms of the Group Health Plan.]

[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 ["DC"
a)] the Employees are [Actively at Work] Full-Time Employees[.] ["DC" and;
b) the Employees enroll under the associated HMO Plan.]
[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.]

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

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 are subject to the Policy's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6 months] of continuous Full-Time service with the Policyholder.]

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.

[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.
["DC" e) [the date] an Employee ceases to be covered under the associated HMO Plan.]

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights..)
   - the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

Dependent children who are under age 26;.

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, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner and]
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.

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. ["DC" Only eligible Dependents who You include for coverage under the associated HMO Plan may be enrolled under this Indemnity Plan.] [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.

Late Enrollees age 19 or older are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a) the date the [Carrier] or [Carrier's] authorized representative or agent receives the signed enrollment form.; or
b) the date You become insured for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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.
["DC" g) the date the Dependent ceases to be covered under the associated HMO Plan.]

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.

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.
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 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.

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

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

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.

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.

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.]

[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 Cash Deductible
[Each Calendar 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 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 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 Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before [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 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.]

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar 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 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 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 Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once [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 Year.

What [Carrier] pays is based on all the terms of the Policy.]

[Per Covered Family
The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more Covered Persons in a family have incurred a combined total of Covered Charges toward their Per Covered Person Cash Deductible equal to the per Covered Family Cash Deductible, each Covered Person in that family will be considered to have met his or her Per Covered Person Cash Deductible for the rest of that Calendar Year. The Covered Charges that each Covered Person in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Covered Person Cash Deductible.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]

[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 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 covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar 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 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 Year. All amounts for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]]

[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 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 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 Year.]]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

Payment Limits
[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. 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 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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by [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 a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care 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.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

[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.
["DC" NOTE: ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

Home Health Care Charges
Subject to [Carrier's] Pre-Approval, when 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.

[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.

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.

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.]
["DC" NOTE: ANY NEWBORN CHILD SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE UNDER THIS INDEMNITY PLAN.]

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.

[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. 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 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 PPO or a POS)

[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)

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. 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

[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.]

Dental Care and Treatment
[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.

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 the 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, [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, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.
Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
[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.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See the Policy's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] section[s] to determine if a Covered Person is a Late Enrollee. [The "Pre-Existing Conditions Limitation provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new Covered Person was covered under Creditable Coverage prior to enrollment under the Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Policy, [Carrier] will provide credit as follows. [Standard method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [[Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage based on coverage for the following [category] [categories]of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [[Carrier] will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits,][Carrier] gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Carrier] counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. [Carrier] applies these days to reduce the duration of the Pre-Existing Condition limitation under the Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Policyholder has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

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 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 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 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.

["DC" NOTE: ANY THERAPY SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPY BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Covered Person is under 21 years of age, 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.

["DC" NOTE: ANY AUTISM AND OTHER DEVELOPMENTAL DISABILITIES SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE AUTISM AND OTHER DEVELOPMENTAL DISABILITIES BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of the Policy.

[Carrier] will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under 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 Year to:
a) $750 per Covered Person for a Dependent child from birth until the end of the Calendar 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.

["DC" NOTE: ANY PREVENTIVE CARE SERVICES OR SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE UNDER THE INDEMNITY PLAN.]

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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

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. Such vision examination is not covered under the Policy.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED HMO PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION BENEFITS AVAILABLE UNDER THIS INDEMNITY PLAN.]

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, breast 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 Year and Per Lifetime 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:

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.

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.

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
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.

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.***

[“DC” Services or supplies provided under the associated ***HMO Plan.***]

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.

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, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by [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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products 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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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 ["DC" ,where this Indemnity Plan is issued in conjunction with an HMO Plan. This Effect of Interaction with a Health Maintenance Organization Plan provision does **not** apply to Employees and their Dependents who are HMO members due to coverage under this Indemnity Plan and the associated HMO Plan.] If the Employer does ["DC" offer HMO membership under an HMO plan *other than* the associated HMO Plan], 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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Covered Person]. The [Covered Person] is liable only for the applicable deductible, coinsurance or copayment. If the [Covered Person] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

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.]

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).

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

[[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:	[September 23, 2010]

[COVERED CLASSES:
[All Employees of the Contractholder (and its Associated Companies) who permanently 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]

["DC" THIS SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT (HMO PLAN), ISSUED BY [CARRIER] IS ISSUED IN CONJUNCTION WITH THE SMALL GROUP HEALTH BENEFITS POLICY (INDEMNITY PLAN) ISSUED BY [CARRIER]. TOGETHER, THIS HMO PLAN AND THE INDEMNITY PLAN ISSUED BY [CARRIER] PROVIDE POINT OF SERVICE COVERAGE.]

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

TABLE OF CONTENTS

["DC" OVERVIEW OF POINT OF SERVICE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK] (Provided under this HMO Plan)	
Copayment	
For Preventive Care	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Services and Supplies for Prescription Drugs]

[NON-NETWORK] (Provided under the Indemnity Plan)	
Cash Deductible (calendar year, all cause)	$2,500 per person except as stated for Preventive Care [$5,000 per family Note: Must be individually satisfied by 2 separate Members] [$7,500]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	
For Preventive Care	NONE
For all other Covered Charges	[30%, 20%]
Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS Unlimited

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 YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS[/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT	[$75, $100, $150, $200, $300, $400, $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [$750, $1000, $1,500, $2,500, $3,000, $4,000, $5,000]/Calendar Year. Unlimited days.
OUTPATIENT	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[$5, $10, $15, $20, $30, $40, $50] 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.

SURGERY:.	
INPATIENT	$0 Copayment
OUTPATIENT	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit
HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.
THERAPEUTIC MANIPULATION	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN For services other than Preventive Care [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.

PRIMARY CARE SERVICES **Other than Preventive Care**	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
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	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
SPECIALIST SERVICES	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
SKILLED NURSING FACILITY/EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES Speech and Cognitive Therapy (Combined), maximum30 visits per Calendar Year See below for the separate speech therapy benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	[$5, $10, $15, $20, $30, $40, $50] Copayment/visit.
Physical and Occupational Therapy (Combined) maximum 30 visits per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per Calendar Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits per Calendar Year
DIAGNOSTIC SERVICES **INPATIENT** **(OUTPATIENT)**	$0 Copayment [$5, $10, $15, $20, $30, $40, $50] Copayment/visit
HEARING AIDS for Members age 15 or younger	[$5, $10, $15, $20, $30, $40, $50] Copayment with coverage limited to $1,000 per hearing impaired ear per 24-month period
SCHEDULE OF SERVICES AND SUPPLIES	[Example Using Deductible, Coinsurance]

The services or supplies covered under this Contract are subject to the Copayments Deductible and Coinsurance set forth below and are determined per Calendar Year per [Member], unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT	
For Preventive Care	NONE
For all other Primary Care Physician Visits	[$5, $10, $15, $20, $30, $0, $50] per visit
Maternity (pre-natal care)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment/initial visit.
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER CALENDAR YEAR	
•For Primary Care Physician Visits including Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•for all other Covered Services and Supplies	
•Per Covered Person	[$250 to $2,500]
•[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%
For all 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 [at the option of the carrier, $50, $75, $100] 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.

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 Year. All amounts paid [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.

The **Maximum Out of Pocket** for the Contract is as follows:

- Per Member per Calendar Year — [An amount not to exceed $7,500]
- [Per Member per Calendar Year — [Dollar amount equal to two times the per Member Maximum.] **[Note:** Must be individually satisfied by 2 separate Members]]

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

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
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 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 Year
Charges for speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits per Calendar Year
Charges for physical and occupational provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits per Calendar Year
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval
Hearing Aids for Members age 15 or younger	[$5, $10, $15, $20, $30, $40, $50] Copayment with coverage limited to $1,000 per hearing impaired ear per 24-month period

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF 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.

["DC" THIS HMO PLAN AND THE ASSOCIATED INDEMNITY PLAN MAY BOTH PROVIDE BENEFITS, SERVICES OR SUPPLIES FOR THE SAME SERVICE OR SUPPLY. TO THE EXTENT THAT BENEFITS ARE PROVIDED UNDER THE INDEMNITY PLAN, THE SERVICE OR SUPPLY WILL NOT BE COVERED BY THIS HMO PLAN. SIMILARLY, TO THE EXTENT THAT SERVICES OR SUPPLIES ARE PROVIDED UNDER THIS HMO PLAN, BENEFITS WILL NOT BE PROVIDED UNDER THE INDEMNITY PLAN.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES PROVIDED UNDER THE CONTRACT WHICH ARE SUBJECT TO LIMITATION, ANY SUCH SERVICES OR SUPPLIES THE [MEMBER] RECEIVES UNDER THIS HMO PLAN WILL REDUCE THE CORRESPONDING BENEFIT PROVIDED UNDER THE INDEMNITY PLAN FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC BENEFITS PROVIDED UNDER THE INDEMNITY PLAN WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS INDEMNITY PLAN COVERED CHARGES WILL REDUCE THE CORRESPONDING HMO PLAN SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE SERVICES AND SUPPLIES SECTION OF THIS HMO PLAN AND THE COVERED CHARGES SECTION OF THE INDEMNITY PLAN CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.]

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.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

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.]

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.

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help [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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights.) 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; and

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, 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 o 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.
e)

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.

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. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of the Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.
a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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.

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 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.

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 CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network][] Providers provide Covered Services and Supplies to[Members].]

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

["DC" HMO PLAN. The Small Group Health Maintenance Organization Contract issued by [Carrier].]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

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

ILLNESS or ILL. A sickness or disease suffered by a[Member] or a description of a [Member] suffering from a sickness or a disease. Illness includes Mental Illness.

["DC" INDEMNITY PLAN. The Small Employer Health Benefits Policy issued by [Carrier] in conjunction with this HMO Plan.]

[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.

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 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 [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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.

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.

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.

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.

["DC" POINT OF SERVICE PLAN. Often referred to as a POS plan, a Point of Service Plan provides coverage for the services of [Network] Providers under an HMO plan as well as the services of [Non-Network] Providers under an Indemnity Plan. 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 Physician) or those of an [Non-Network] Provider. [Non-Network] charges are usually greater than the [Network] charges, and are subject to a Deductible and Coinsurance. In addition, the [Member] may be liable to pay charges that exceed the amount the Indemnity Plan carrier Determines to be the Allowed Charge for a service or supply.]

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.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition. See the **Non-Covered Services and Supplies** section of the Contract for details on how the Contract limits the services for Pre-Existing Conditions.]

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; 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 PHYSICIAN (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member]'s Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

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.

PUBLIC HEALTH PLAN. 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.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that 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. 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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)].

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.

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.

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

[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.]

[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 ["DC"
a)]the Employees are [Actively at Work] Full-Time Employees[.]["DC" and;
b) the Employees enroll under the associated Indemnity Plan.]
[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.]

For purposes of the Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility**.

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 are subject to the Contract's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
The Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Contractholder.]

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Contract's eligibility waiting period if:
a) the Employee was employed by the Contractholder on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date We or Our authorized representative or agent receive the signed enrollment form.

[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 moves his or her permanent residence outside the Service Area.]
["DC" f) [the date] an Employee ceases to be insured under the associated Indemnity Plan.]

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil civil union partners have COBRA rights..) 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.]

Adopted Children and Step-Children
Your " Dependent children" include Your legally adopted children, Your step-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. ["DC" Only eligible Dependents who You include for coverage under the associated Indemnity Plan may be enrolled under this HMO Plan.] [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.

Late Enrollees age 19 or older are subject to the Contract's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date We or Our authorized representative or agent receives the enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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.]
["DC" h) the date the Dependent ceases to be insured under the associated Indemnity Plan.]]

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 PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services ["DC" under this HMO Plan] only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

["DC" Note: Under the terms of the associated Indemnity Plan, there is no requirement that the Member contact a Primary Care Physician to access services or supplies, but all benefits are subject to the terms and conditions of the associated Indemnity Plan.]

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [Mental Illness, or Substance Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Physician from Our [Physician or Practitioners] Directory].

[For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to 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 Physician.

Except in the case of an Emergency, a [Member] will not be eligible for any services ["DC" under this HMO Plan] provided by anyone other than a [Member's] Primary Care Physician (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences ["DC" under this HMO Plan]. 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 [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under the Contract.

LIMITATION ON SERVICES
Except in cases of Emergency, services ["DC" under this HMO Plan] are available only from Network Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a [Member] from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT
[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service"] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member], the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 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 Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered

Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by 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 Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of the Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

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 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

["DC" Under this HMO Plan,] [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 Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior written Referral by a [Member]'s Primary Care Physician [or Health Center] [or the Care Manager]:
1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Home visits** by a [Member]'s Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member]'s employment).
4. **Diagnostic Services**.
5. **Casts and dressings.**
6. **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a [Member]'s Primary Care Physician and Pre-Approved by Us.
7. **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. 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 Physician and arranged through Us.

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.
[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. 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.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member]'s Primary Care Physician and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

    For the purpose of this benefit:
    "inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
    "low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
    "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.
15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
    a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
    b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
    We may review continued Medical Necessity and Appropriateness of the specialized infant formula.
16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

    We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

    We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.
18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

    Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:
    a) 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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the 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 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. 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.]

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office [, or Health Center,] or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior written Referral by a [Member]'s Primary Care Physician.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written referral from a [Member]'s Primary Care Physician, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:

1. Semi-private room and board accommodations
Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the [Member], in consultation with the Network Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

As an exception to the Medically Necessary and Appropriate requirement of 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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

2. Private accommodations [will be provided only when Pre-Approved by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestines.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

25. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations or comfort items.

(d) BENEFITS FOR 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 referral by a [Member]'s Primary Care Physician [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 ["DC" under this HMO Plan] without prior written Referral by a [Member]'s Primary Care Physician in the event of an Emergency as Determined by Us.

1. A [Member]'s Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:
   a. Our review Determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
   b. The service rendered is provided as a Covered Service or Supply under 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 Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event a [Member] is Hospitalized in a Non-Network Facility, coverage will only be provided until the [Member] is medically able to travel or to be transported to a Network Facility. If the [Member] elects to continue treatment with Non-Network Providers, We shall have no responsibility for payment beyond the date the [Member] is Determined to be medically able to be transported.
   In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written Referral to a Network Provider.
4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the [Member] shall be responsible for payment.
   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 Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
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 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 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.

["DC" NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPY SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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.

["DC" NOTE: ANY AUTISM AND OTHER DEVELOPMENTAL DISABILITIES SERVICES AND SUPPLIES A COVERED PERSON RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE AUTISM AND OTHER DEVELOPMENTAL DISABILITIES BENEFITS AVAILABLE UNDER THIS HMO PLAN.]

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Physician. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;
8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the [Member] had been in a Hospital; and
9) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Contract and to the following conditions:

a. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.
b. The services and supplies must be:
   1. ordered by the [Member's] Practitioner;
   2. included in the home health care plan: and
   3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

c. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
e. We do not pay for:
   1. services furnished to family members, other than the patient; or
   2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

["DC" NOTE: ANY NURSING CARE BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE NURSING CARE SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(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 Physician. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(j) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a [Member] who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by 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 Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.
["DC" NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS A [MEMBER] RECEIVES UNDER THE ASSOCIATED INDEMNITY PLAN WILL REDUCE THE THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES AVAILABLE UNDER THIS HMO PLAN.]

(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.]

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THE CONTRACT.

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.

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.

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
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 intrafallopian 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.

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.

["DC"[Services or supplies for which benefits are paid under the associated **Indemnity Plan.]**

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.

[Pre-Existing Condition Limitations:
The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Contractholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Contract. See the Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [31] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.
We do not pay benefits for charges for Pre-Existing Conditions for Members age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under the Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under the Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. [We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits,] We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under the Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. We do not cover any charges actually incurred before the person's coverage under the Contract starts. If the Contractholder has included an eligibility waiting period in the Contract, an Employee must still meet it, before becoming covered.]

Any service provided without prior written Referral by the [Member]'s **Primary Care Physician,** 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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products except as provided in the Nutritional Counseling and Food and Food Products for Inherited Metabolic Diseases items of the Contract.

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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under 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. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force.

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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

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.

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).

EXHIBIT Z

(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.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).
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 Z: Rider for Prescription Drug Insurance".

EXHIBIT HH

[Carrier] **HMO - POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)
POINT OF SERVICE (POS) CONTRACT

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [September 23, 2010]

CONTRACT ANNIVERSARIES: [September 23rd of each year, beginning in 2011.]

PREMIUM DUE DATES: [Effective Date, and the 23rd day of the month beginning with October 2011.]

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]]

TABLE OF CONTENTS

SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Covered Employee Only ..... $]

[Covered Employee and Spouse..... $

Covered Employee and Child(ren) ..... $

Covered Employee and Family ..... $
(including Covered Employee, spouse and one or more eligible dependents)]

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]

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]	
Copayment	
For Preventive Care	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

[NON-NETWORK]	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	$2,500]
Per Covered Family	$5,000 NOTE: Must be individually satisfied by 2 separate [Members]] [$7,500]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	
for Preventive Care	NONE
for all other Covered Charges	[30%, 20%]
Network Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS

[NETWORK]	Unlimited,
[NON-NETWORK]	Unlimited

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)

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

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
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
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
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	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care	Covered; $0 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)

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 Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	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	Coinsurance	Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
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 Year

Network	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]
Non-Network	
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] **Note**: Must be individually satisfied by 2 separate Covered Persons

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 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 Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.

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

Per member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar Year.

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

Per Member per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member Maximum.] [**Note:** Must be individually satisfied by 2 separate Member]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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)

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 Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	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	Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	No Deductible or Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

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 Year

Network and Non-Network

Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]

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 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 Member 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 Year.

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

Per Member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined)	
Network:	Unlimited
Non-Network:	120 days
Charges for therapeutic manipulation per Calendar 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 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 Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows:	
Network:	Unlimited

Non-Network: (Not subject to Cash Deductible or Coinsurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$750 per Member]
• for all [other] Members	$500 per Member
Charges for hearing aids for Members age 15 or younger	Maximum benefit $1,000 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 PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. 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 [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. 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.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

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.

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.

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights.) 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;

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, 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 [or the Care Manager] Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

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

EFFECTIVE DATE. The date on which coverage begins under this Contract for 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. Partners, proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] 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 [or the Care Manager] 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 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.

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 CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] Providers provide Covered Services and Supplies to [Members].]

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

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

ILLNESS or ILL. A sickness or disease suffered by a [Member] or a description of a [Member] suffering from a sickness or 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.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a 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, 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 [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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.

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.

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.

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 [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. 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.

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of this Contract for details on how this Contract limits the services and benefits for Pre-Existing Conditions.]

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; 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 PHYSICIAN (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 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.

PUBLIC HEALTH PLAN. 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.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the 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.

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. 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least eligible two Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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].

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.

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.

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

[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.]

[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 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.]

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility**.

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 are subject to this Contract's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Contractholder.]

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:
a) the Employee was employed by the Contractholder on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date the We or Our authorized representative or agent receives the signed enrollment form.

[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.

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights.) 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;

[Exception: Any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children and Step-Children
An Employee's "Dependent children" include the Employee's legally adopted children, his or her step-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.

Late Enrollees age 19 or older are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date We or Our authorized representative receives the signed enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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 PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [Mental Illness or, Substance Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Physician from Our [Physician or Practitioners] Directory].

For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of [Member's]

coverage. If the [Member] who misuses the card is the 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 Physician.

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 Physician (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding 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 [or the Care Manager] 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 Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

PROVIDER PAYMENT
[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service"] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If

a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member], the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 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 Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

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 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 Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine 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 Physician and Pre-Approved by Us.
7) **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. 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 Physician and arranged through Us.
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.

[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. 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.

11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and Pre-Approved by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14) **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member's] Practitioner.

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

15) **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16) Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17) **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a [Network] Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18) **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

a) 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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.
NOTE: ANY HEARING AID BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] HEARING AID SERVICES AND SUPPLIES.

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. 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.]

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] 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 Physician.

(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 Physician, 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 such 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

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.

19. The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
20. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

21. 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. 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 Physician [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 Referral by a [Member's] Primary Care Physician in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.

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 Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for services received unless We [or the Care Manager] 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 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] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
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 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 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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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 Physician. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;
8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the [Member] had been in a Hospital; and
9) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Contract and to the following conditions:

a. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.
b. The services and supplies must be:
1. ordered by the [Member's] Practitioner;
2. included in the home health care plan: and
3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

c. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.

e. We do not pay for:

1. services furnished to family members, other than the patient; or
2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

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 Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(j) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a [Member] who is severely disabled or who is a Child under age 6, We cover:

a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

(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 Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

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.]

[NON-NETWORK] BENEFIT PROVISION *APPLICABLE TO [NON-NETWORK] BENEFITS*

The Cash Deductible

Each Calendar 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 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 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 Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Per Covered Family
The Per Covered Family Calendar 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 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.]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

[Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. All amounts [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 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 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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

If a [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 a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care 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 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.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

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.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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 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 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.

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.

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.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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.

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. 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. 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.]

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.]

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a [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 Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of this Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every year, for a female [Member] ages 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female [Member] may elect to apply any unused Preventive Care allowance for a mammogram. If a [Member] has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a 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 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 [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 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 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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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. 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 Year to:
a) $750 per [Member] for a Dependent child from birth until the end of the Calendar 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.

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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

ANY HEARING AID SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE HEARING AID BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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. Such vision examination is not covered under this Contract.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar 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.**

[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.

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.

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.

Services or supplies for or in connection with:

a. except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following [members] of 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 intrafallopian 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.

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.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Contractholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is under age 19 or who is an adopted child or-who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for Members age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must

sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service beginsWe do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Contractholder has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** 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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products 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 Year and Per Lifetime maximums.

Exclusion
Specialty Case Management does not include services and supplies that We [or the Care Manager] 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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

SERVICES 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 eligible Employee 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; or
e. the Employee is covered under another group health benefits plan.

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

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. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force.

[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 180 days advance written notice to the Contractholder for the following reasons:

a) subject to the statutory notification requirements, We cease to do business in the 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.

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 Employees are covered by this Contract. If an eligible 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; or
    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; or
    5. The employee is covered under another group health benefits plan,

    We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;
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

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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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.

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 AS SECONDARY PAYOR (Continued)

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).

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 Physician) 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 Physicians and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Physician, 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 Physician). [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 physician 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 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 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 Reasonable and Customary 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.

[Carrier] HMO - POS PLAN

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: [September 23, 2010]

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]]

TABLE OF CONTENTS

SECTION PAGE

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]	
Copayment	
For Preventive Care	NONE
For all other Services and Supplies	$[15], unless otherwise stated
Emergency Room Copayment	[$50], credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

[NON-NETWORK]	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	$2,500]
Per Covered Family	[$5,000 NOTE: Must be individually satisfied by 2 separate [Members]] [$7,500]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	
for Preventive Care	NONE
for all other Covered Charges	[30%, 20%]
Network Maximum Out of Pocket	$7,500

MAXIMUM LIFETIME BENEFITS

[NETWORK]	Unlimited, **except** as otherwise stated
[NON-NETWORK]	$Unlimited

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)

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
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment/visit	Deductible/Coinsurance
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
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	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care	Covered; $0 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)

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 Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	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	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 Year

Network	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note:** Must be individually satisfied by 2 separate Covered Persons]]
Non-Network	
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] **Note:** Must be individually satisfied by 2 separate Covered Persons

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 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 Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies [other than Prescription Drugs] for the remainder of the Calendar Year.
The **Network Maximum Out of Pocket** for this Contract is as follows:

Per member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs.

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

Per Member per Calendar Year	[An amount not to exceed three times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member Maximum.] [**Note:** Must be individually satisfied by 2 separate Member]]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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)

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 Physician Visits	[$15] Copayment/visit	Deductible/Coinsurance
Maternity	[$25] Copayment for initial visit only; $0 Copayment thereafter	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	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 Year

Network and Non-Network	
Per Covered Person	[$250 to $2,500]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.] [**Note**: Must be individually satisfied by 2 separate Covered Persons]]

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

Per Member per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Member maximum.] [**Note:** Must be individually satisfied by 2 separate Members]]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges [or with charges for Prescription Drugs].

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 Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined)	
Network:	Unlimited
Non-Network:	120 days
Charges for therapeutic manipulation per Calendar 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 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 Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows:	
Network:	Unlimited
Non-Network: (Not subject to Cash Deductible or Coinsurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$750 per Member]
• for all [other] Members	$500 per Member
Charges for hearing aids for Members age 15 or younger	Maximum benefit $1,000 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 PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. 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, 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. 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.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

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.

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.

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); Title XXI of the Social Security Act (State Children's Health Insurance Program), chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for

on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help 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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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. (Neither domestic partners nor civil union partners have COBRA rights.) 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;

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, 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 [or the Care Manager] Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

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

EFFECTIVE DATE. The date on which coverage begins under 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. Partners, proprietors, and independent Contractors will be treated like Employees, if they meet all of the Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

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.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] 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 [or the Care Manager] 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 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.

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 CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] Providers provide Covered Services and Supplies to [Members].]

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission; or
b) be approved as a Hospital by Medicare.

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

ILLNESS or ILL. A sickness or disease suffered by a [Member] or a description of a [Member] suffering from a sickness or 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.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a 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, 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 [or Our associated medical groups] to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

[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.

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.

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.

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 [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. 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.

PRE-EXISTING CONDITION. For a member age 19 or older, an Illness or Injury which manifests itself in the six months before a Member's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

[PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of the Contract for details on how the Contract limits the services and benefits for Pre-Existing Conditions.]

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; 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 PHYSICIAN (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 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.

PUBLIC HEALTH PLAN. 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.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the 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.

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. 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 two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least eligible two Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. 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.

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].

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.

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.

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

[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.]

[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 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.]

For purposes of the Contract, We will treat partners, proprietors and independent Contractors like Employees if they meet the Contract's **Conditions of Eligibility**.

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 are subject to the Contract's Pre-Existing Conditions limitation, if any applies.

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], 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.]

[The Waiting Period
The Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under the Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Contractholder.]

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Contract's eligibility waiting period if:
a) the Employee was employed by the Contractholder on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

Any lapse in continuous service due to an absence which results from a Health Status-Related Factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

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. Coverage is scheduled to start on the date the We or Our authorized representative or agent receives the signed enrollment form.

[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.

[DEPENDENT COVERAGE

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 the Federal Defense of Marriage Act, 1 U.S.C.A. 7, 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) (Neither domestic partners nor civil union partners have COBRA rights.) 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.]

Adopted Children and Step-Children
Your "unmarried Dependent children" include Your legally adopted children, Your step-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.

Late Enrollees age 19 or older are subject to the Contract's Pre-Existing Conditions limitations section, if any applies.

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 Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date We or Our authorized representative receives the signed enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

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 Dependent's Eligibility Date for the Newly Acquired Dependent.

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 PHYSICIAN
A [Member's] Primary Care Physician provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Physician [or the Care Manager] and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We [or the Care Manager] Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [Mental Illness or Substance Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Physician, [Members] can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Physician from Our [Physician or Practitioners] Directory].

For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

IDENTIFICATION CARD
The Identification Card issued by Us to [Members] pursuant to 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 Physician.

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 Physician (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Physician. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Physician.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A [Member] has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A [Member] has the right to participate in decision-making regarding the [Member's] care. Further, a [Member] may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a [Network] Practitioner. A [Member] who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another [Network] Practitioner. If such [Network] Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the [Network] Practitioner shall inform the [Member] of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the [Member] and or the [Member's] family or other person acting on the [Member's] behalf. If the [Member] refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the [Member] in writing that We will not provide further benefits or services for the particular condition or its consequences. The [Member's] decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding 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 [or the Care Manager] 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 Physician or a Provider referred in writing by the Primary Care Physician 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 Physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the [Member], the [Member] should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 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 Cash Deductible
Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs] for the remainder of the Calendar 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 Year.]

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 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 Physician's office [or Health Center] selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Physician [or Health Center] [or the Care Manager].

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine 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 Physician and Pre-Approved by Us.
7) **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. 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 Physician and arranged through Us.
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.

[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. 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.
11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and 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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.
NOTE: ANY HEARING AID BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] HEARING AID SERVICES AND SUPPLIES.

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. 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.]

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office [, or Health Center,] 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 Physician.

(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 Physician, 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 such 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

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.

19. The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
20. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]

[23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

21. 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. 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 Physician [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 Referral by a [Member's] Primary Care Physician in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Physician [or Health Center] [or Us] [or the Care Manager] prior to seeking Emergency treatment.
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 Physician are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for

services received unless We [or the Care Manager] 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 Covered person 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 Physician [or the Care Manager]. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
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 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 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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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 Physician. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;
8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the [Member] had been in a Hospital; and
9) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Contract and to the following conditions:

a. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.
b. The services and supplies must be:
1. ordered by the [Member's] Practitioner;
2. included in the home health care plan: and
3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.
c. The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
e. We do not pay for:
1. services furnished to family members, other than the patient; or
2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

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 Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(j) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. We cover:
1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a [Member] who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by 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 Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l) **THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

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.]

[NON-NETWORK] BENEFIT PROVISION ***APPLICABLE TO [NON-NETWORK] BENEFITS***

The Cash Deductible
Each Calendar 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 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 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 Year. Once two [Members] in a family meet their individual Cash Deductibles in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of the Contract.]

[Per Covered Family

The Per Covered Family Calendar 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 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.]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts [for services and supplies other than Prescription Drugs] 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 [other than Prescription Drugs]for the remainder of the Calendar 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 Year.]

[Once any combination of Covered Persons in a family meet an amount equal to [three] times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

[Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. All amounts [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 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 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 such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

If a [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 a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care 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
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.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

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.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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 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 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.

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.

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.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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.

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. 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. 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.]

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.]

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while 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.

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 Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a female [Member] according to the schedule given below. Benefits will be paid, subject to all the terms of the Contract, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every year, for a female [Member] ages 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female [Member] may elect to apply any unused Preventive Care allowance for a mammogram. If a [Member] has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a 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 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 [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 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 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 and 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 Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. 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, and the Member is under 21 years of age, 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. 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 Year to:
a) $750 per [Member] for a Dependent child from birth until the end of the Calendar 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.

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 subject to a maximum amount payable for each hearing aid of $1,000. 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 as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.
ANY HEARING AID SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE HEARING AID BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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. Such vision examination is not covered under the Contract.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar 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 <u>NOT</u> COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE <u>NOT</u> COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THE CONTRACT.

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.

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.

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
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.

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.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Contractholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Contract. See the Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is under age 19 or who is an adopted child or-who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for members age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any **Waiting Period**, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under the Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THE CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under the Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under the Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's [active] Full-Time service begins. We do not cover any charges actually incurred before the person's coverage under the Contract starts. If the Policyholder has included an eligibility waiting period in the Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** 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.

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, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products 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 Year and Per Lifetime maximums.

Exclusion
Specialty Case Management does not include services and supplies that We [or the Care Manager] 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 Year, or portion of a Calendar 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 Year shall be determined before those of the parent whose birthday falls later in the Calendar 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 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." 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.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is 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 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 and Secondary Plan is an HMO
If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Member] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

SERVICES 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. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force.

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 continue group health benefits, the Over-Age Dependent must make written election to [the Carrier]. 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 age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

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 at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

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]. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent 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 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. Evidence of insurability is not required for the continued coverage.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 6 months after your enrollment date in your coverage.

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.]

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).

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).