This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan [A/50] [B] [C] [D].

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

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

EFFECTIVE DATE OF POLICY: [January 1, 2009]

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

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

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

[Secretary President]

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

POLICY INDEX

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

Calendar Year Cash Deductible

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

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

Coinsurance

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

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

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

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

Per Covered Person per Calendar Year	[$6,000, $7,500, $10,000, $15,000]
[Per Covered Family per Calendar Year	[$12,000, $15,000, $20,000, $30,000]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A/50

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan A/50]

Calendar Year Cash Deductible

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

Per Covered Person per Calendar Year	$6,000
[Per Covered Family per Calendar Year	$12,000

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

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

Calendar Year Cash Deductible

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

Hospital Confinement Copayment

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

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

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

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

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN B

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan B by Carriers that elect to offer Plan B as an indemnity plan.]

Calendar Year Cash Deductible

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

Hospital Confinement Copayment

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

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

Per Covered Person per Calendar Year	$4,000
Per Covered Family per Calendar Year	$8,000

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

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN C]

Calendar Year Cash Deductible

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

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

Coinsurance

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

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

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

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

Per Covered Person per Calendar Year	[$3,500, $5,000, $7,500, $12,500]
Per Covered Family per Calendar Year	[$7,000, $10,000, $15,000, $25,000]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN C

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan C by carriers that elect to offer Plan C as an indemnity plan]

Calendar Year Cash Deductible

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

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

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

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]

Calendar Year Cash Deductible

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

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

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

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN D

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan D by carriers that elect to offer Plan D as an indemnity plan]

Calendar Year Cash Deductible

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

Maximum Out of Pocket

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

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

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

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

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

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

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children as detailed in the Immunizations and Lead Screening provision	NONE
For all other Covered Charges	

Note to carriers: Use the following text for MSA plans

- for all other Covered Charges

[per Covered Person	[$1,500][$2,250]][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[1550, $2300]]
per Covered Family	[$3,000][$4,500[Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [1999], the amount is $[3050, $4600]

Note to carriers: Use the following text for HSA plans

- for all other Covered Charges

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

Coinsurance

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

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

Maximum Out of Pocket

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

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

Note to carriers: Use the following text for MSA plans

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

Note to carriers: Use the following text for HSA plans

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

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

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

Calendar Year Cash Deductibles

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

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	

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

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

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	

Per Covered Person	[$2,000, $5,000]
Per Covered Family	[$4,000, $10,000]

Emergency Room Copayment

(waived if admitted within 24 hours) 100

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

Coinsurance

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

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

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

• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**

• if treatment, services or supplies are given by a Non-Network Provider 30%, **except as stated below**

Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is: 30%

Network Maximum Out of Pocket

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

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

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

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

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

Non-Network Maximum Out of Pocket

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

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

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

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

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

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

Copayment

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

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

Calendar Year Cash Deductibles

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

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

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

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**

• if treatment, services or supplies are given by a Non-Network Provider 30%, **except as stated below**

Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is: 30%

Network Maximum Out of Pocket

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

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

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

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

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

Non-Network Maximum Out of Pocket

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

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

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

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

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

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

Copayment

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

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

Calendar Year Cash Deductible

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

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

Per Covered Family [$2,000, $5,000]

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

• if treatment, services or supplies are given by a Network Provider 10%, **except as stated below**

• if treatment, services or supplies are given by a Non-Network Provider 30%, **except as stated below**

Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is: 30%

Network Maximum Out of Pocket

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

to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$7,500
Per Covered Family per Calendar Year	$$15,000

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

SCHEDULE OF INSURANCE EXAMPLE POS (using Plan D, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Copayment

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

Physician Visits	[$15, $30, $40 or $50]
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	[$1000 or $2,500]
[Per Covered Family	[$2,000 or $5,000]

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

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

Emergency Room Copayment

(waived if admitted within 24 hours) $100

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

Coinsurance

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

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

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

• 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. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

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

Non-Network Maximum Out of Pocket

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

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

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

Per Covered Person per Calendar Year	[An amount not to exceed two times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.]

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

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) [PLANS A/50, B, C, D]

Daily Room and Board Limits

During a Period of Hospital Confinement

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

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

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

Pre-Approval is required for charges incurred in connection with:

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

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

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

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

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

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

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

Inpatient Confinement	30 days *
Outpatient Care	20 visits

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

Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

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

Two Adults..... $

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

Family Coverage.....$]

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

DEFINITIONS

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

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

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

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 considered 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.

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

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

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

[**Approved Cancer Clinical Trial** means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:

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

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

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

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

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

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

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

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

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

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

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

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

Covered Charges are 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, We pay benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what We limit or exclude.

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

Creditable Coverage means, coverage under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation (Please refer to the definition of Public Health Plan in this Policy and note the different meaning of the term with respect to a Federally Defined Eligible Individual and a person who is not a Federally Defined Eligible Individual); a health benefits plan under section 5(e) of the "Peace Corps Act"; Title XXI of the federal Social Security Act (State Children's Health Insurance Program), or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

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

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

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

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

Dependent means Your:
a) Spouse;
b) unmarried Dependent child who is under age 19; and
c) unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an Accredited School. Full-time student status will be as

defined by the Accredited School. We can require periodic proof of a Dependent child's status as a full-time student.

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

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

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

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

A Dependent does not include a person who resides in a foreign country. However, this does not apply to a person who is attending an Accredited School in a foreign country who is enrolled as a student for up to one year at a time.

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

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

assistance that are lifelong or of extended duration and are individually planned and coordinated.

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

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

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

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

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

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

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

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

Eligible Person means a person who is a Resident of New Jersey who is not eligible to be covered under a Group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare).

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

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

Experimental or Investigational means We determine a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

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

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

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device

Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

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

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means a place We are required by law to recognize which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation.

Federally Defined Eligible Individual means an Eligible Person, as defined:

a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months during which time the Eligible Person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the Eligible Person has no Creditable Coverage);
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

Governmental Plan has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

Group Health Plan means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. §1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or

health maintenance organization subscriber contract or certificate or any other similar contract, policy, or plan delivered or issued for delivery in New Jersey, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. We will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

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

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

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

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

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

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

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

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

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

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

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

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

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

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

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

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

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

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

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

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. We determine if the cause(s) of the confinements are the same or related.

Pharmacy means a facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

Policyholder means the person who purchased this Policy.

Practitioner means a person We are required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

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

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before Your Enrollment Date, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

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

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

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

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

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

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

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

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

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

Resident means a person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year, except as stated below; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year, except as stated below.

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

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

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

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

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

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

Specialist Doctor means a doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialist Services mean Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females)].

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

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

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

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

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

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

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

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

ELIGIBILITY

Types of Coverage

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

- **Single Coverage** - coverage under this Policy for only one person.
- **Family Coverage** - coverage under this Policy for You and Your Dependent(s).
- **Adult and Child(ren) Coverage -** coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
- **Single and Spouse Coverage** - coverage under this Policy for You and Your Spouse.

Who is Eligible

The Policyholder -You, if You are an Eligible Person.
Spouse - Your Spouse who is an Eligible Person **except:** a Spouse need not be a Resident.
Child - Your child who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy, **except**: a Child need not be a Resident.

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

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

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

The child's coverage ends when Your coverage ends.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Covered Person is a Resident.

Eligibility if you have or are eligible for other coverage

Eligibility if you are covered under another individual health benefits plan - You and/or Your Dependents are eligible for coverage under this Policy if this Policy replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that Plan. We may require proof that the other coverage has been terminated.

Eligibility if you are eligible for coverage under a group health benefits plan - You and/or Dependents may be eligible for coverage under this Policy only during the open enrollment period which occurs each year during the month of November for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

Adding dependents to this Policy

Spouse - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage or documentation of domestic partnership or civil union, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

Newborn Children - We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:

If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. You must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under this Policy.

If You are not covered for Dependent child coverage on the date the child is born, You must: a) give written notice to enroll the newborn child; and b) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, such coverage will become effective on the first day of the month after the date Your application is received.

Child Dependent - If You have Single or Two Adult Coverage and want to add a child Dependent, other than a Newborn Child, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a child. If Your written notice to add a child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

Please note: A Child born to Your Child Dependent is not covered under this Policy unless the Child is eligible to be covered as Your Dependent, as defined.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers. The up-to-date lists will be furnished automatically, without charge.

Use of the network is strictly voluntary, but We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

In the case of Urgent Care or an Emergency, a Covered Person may go to a [XYZ Health Care Network] provider or a non-[XYZ Health Care Network] provider. If a Covered Person receives Urgent Care or care and treatment for an Emergency from a non-[XYZ Health Care Network] provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment were provide by a [XYZ Health Care Network] provider. However, follow-up care or treatment by a non-[XYZ Health Care Network] provider will be treated as Network benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the [XYZ Health Care Network] service area.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What We pay is subject to all the terms of this Policy. You should read Your Policy carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your Policy, You should call Us.

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

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

POINT OF SERVICE PROVISIONS
[Use if referral is required.]

Definitions
a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. We will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule 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.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if the PCP obtains approval from Us and refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and We are 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 although 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, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from her PCP. She must obtain authorization from her PCP for other services.

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 in addition to whatever copayment, deductible or coinsurance apply to the services an supplies received, and such visits must be retrospectively reviewed [by the PCP]. We 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 us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment

were 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 We pay 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. 8:38-17.3(a)11]

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Provider may be paid] [each time he or she treats a Covered Person ("fee for service"] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a Covered Person desires additional information about how 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 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 gated POS.]

POINT OF SERVICE PROVISIONS
[Use if referral is not required.]

Definitions
a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person [may] [must] select who is available to supervise and coordinate his or her health care in the [XYZ] Provider Organization. We will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner or any other Practitioner in the network provides care, treatment, services, and supplies to the Covered Person.
d) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided for care, treatment, services, and supplies given by a non-network provider.
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 does *not* require that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. A Covered Person may elect to seek guidance from his or her PCP regarding care, treatment, services or supplies. To the extent a Covered Person seeks care, treatment, services or supplies from a network provider, network benefits will be provided. 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 is available to supervise and coordinate the Covered Person's health care in the [XYZ] PO.

As long as services or supplies are obtained from [XYZ] Providers, the Covered Person will be eligible for Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing]. 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 network provider, he or she must present his or her ID card and pay the Copayment, if applicable. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

Non-Network Services

If a Covered Person uses the services of a non-network Provider, he or she will be eligible for Non-Network Benefits. However, 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 or Us within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment in addition to whatever copayment, deductible or coinsurance apply to the services an supplies received. . We 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 Us within 48 hours, or as soon as reasonably possible, We will provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment were 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 We pay 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. 8:38-17.3(a)11]

[[Different] providers in Our Network have agreed to be paid [in different ways byUs. A Provider may be paid] [each time he or she treats a Covered Person (“fee for service”] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services (“capitation”)] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more (“bonuses”) or less (“withholds”) based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a

Covered Person desires additional information about how Our primary care physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

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

[Note: Used only if coverage is offered as non-gated 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.

[CONTINUATION OF CARE

We shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Our Provider network of a Covered Person's PCP and any other Provider from which the Covered Person is currently receiving a course of treatment, as reported to Us. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a determination of fraud, or where Our medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional. In case of pregnancy of a Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a Covered Person who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Covered Person receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with Us.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Us.

If a Covered Person is admitted to a health care Facility on the date this Policy is terminated, We shall continue to provide benefits for the Covered Person until the date the Covered Person is discharged from the facility or exhaustion of the Covered Person's benefits under this Policy, whichever occurs first.

We shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The

determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Policy. We shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with Us.

If We refer a Covered Person to a Non-Network provider, the service or supply shall be covered as a Network service or supply. We are fully responsible for payment to the health care professional and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: Our payments will be reduced if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

[Copayment
The Schedule lists the Copayment(s) that apply to specific services and supplies. The applicable Copayment must be paid each time a Covered Person receives a service or supply for which a Copayment is required.]

[The Cash Deductible]
[Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before We pay any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what We pay is based on all the terms of this Policy.]
[Note to carriers: Use the above deductible text for indemnity plans that are not high deductible health plans that could be used in conjunction with an MSA or an HSA.]

[This Policy has two different Cash Deductibles. One is for treatment, services or supplies given by a Network Provider. The other is for treatment, services or supplies given by a Non-Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from

a Non-Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
[Note to carriers: Use the above deductible text for PPO plans that are not high deductible health plans that could be used in conjunction with an MSA or an HSA.]

[The Cash Deductible:
For Single Coverage Only
Each Calendar Year, You must have Covered Charges that exceed the per Covered Person Cash Deductible before We pay any benefits to You for those charges. The per Covered Person Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by You while insured can be used to meet the Cash Deductible.

Once the per Covered Person Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.]

[Note to carriers: Use the above For Single Coverage Only text for plans that are high deductible health plans that could be used in conjunction with an MSA or an HSA]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once Covered Persons in a family meet the family Cash Deductible in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Policy.]
[Note to carriers, use one of the above text for Family Deductible Limit for an indemnity plan that is not a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

[Family Deductible Limit
This Policy has two different family deductible limits. One is for treatment, services or supplies given by a Network Provider. The other is for treatment services or supplies given by a Non-Network Provider.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment,

services or supplies given by a Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Non-Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

What We pay is based on all the terms of this Policy.]
[Note to carriers, use one of the above text for Family Deductible Limit for a PPO plan that is not a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

[Family Deductible Limit:
For Other than Single Coverage
The per Covered Person Cash Deductible is **not** applicable. This Policy has a per Covered Family Cash Deductible which applies in all instances where this Policy provides coverage that is not single only coverage. Once any combination of Covered Persons in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Calendar Year.]

Note to carriers: Use the above text for other than single coverage for a plan that is a high deductible health plan that could be used in conjunction with an MSA or an HSA.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person

has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use this Maximum Out of Pocket text for a pure indemnity plan that is not high deductible health plans that could be used in conjunction with an MSA or an HSA]

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

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

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

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

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be

required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

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

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

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

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

[Maximum Out of Pocket:
The Per Covered Person and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Covered Person, the Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance for all covered services and supplies in a Calendar Year. Once the Per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance for all

covered services and supplies in a Calendar Year. Once the Per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance will be required for members of the covered family for the rest of the Calendar Year.]
[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

Payment Limits
We limit what We will pay for certain types of charges.

Benefits From Other Plans
The benefits We will pay will be affected by a Covered Person's being covered by or eligible for Medicare. Read the provision **Coordination of Benefits and Supplies with Medicare** to see how this works.

[PLAN B]

COVERED CHARGES

This section lists the types of charges We will consider as Covered Charges. But what We will pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Hospital Charges

We cover charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

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

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

Hospital Copayment Requirement
Each time a Covered Person is confined in a Hospital, or Extended Care or Rehabilitation Center, he or she must pay a $200 Copayment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Copayment per Calendar Year.

[PLANS A/50, C, D]

COVERED CHARGES

This section lists the types of charges We will consider as Covered Charges. But what We will pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Hospital Charges

We cover charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, We cover charges for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and

b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

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

a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and

b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

We provide such coverage subject to the following:

a) the attending Practitioner must determine that Inpatient care is medically necessary; or

b) the mother must request the in-patient care.

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

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

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, [subject to this Policy's **Emergency Room Copayment Requirement** section] *[note to carriers: delete this emergency room copayment phrase if the plan is issued in conjunction with an MSA or HSA].*

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

[PLANS A/50, B,C,D]

Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a $100.00 Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical condition exists. [Please note that the "911" emergency response system may be used whenever a Covered Person has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

Pre-Admission Testing Charges
We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

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

But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

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

Home Health Care Charges

Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a Covered Person under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Covered Person had been in a Hospital; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.

b. The services and supplies must be:
   1. ordered by the Covered Person's Practitioner;
   2. included in the home health care plan: and
   3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

   The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.

d. We do not pay for:
   1. services furnished to family members, other than the patient; or
   2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

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

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Practitioner's Charges for Non-Surgical Care and Treatment
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But We limit what We will pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

We do not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.
"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally Ill or terminally Injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services;
d) treatment not included in the Hospice care plan; or
e) services supplied to family persons who are not Covered Persons.

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

Alcohol Abuse
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is

prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Treatment for Biologically-based Mental Illness
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Biologically-based Mental Illness the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. We do not pay for Custodial Care, education, or training.

Pregnancy
This Policy pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained below.

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of this Policy, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches We cover Medically Necessary and Appropriate replacements or repairs for braces, trusses, orthopedic footwear and crutches.

Blood

Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
We cover Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

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

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

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) replacements or repairs; or
b) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

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
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Policy.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

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

Food and Food Products for Inherited Metabolic Diseases
We covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the Covered Person's Practitioner.

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the

direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

Specialized Infant Formulas
We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Policy] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

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

X-Rays and Laboratory Tests
We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
[Subject to Our Pre-Approval, for certain Prescription Drugs] We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But We only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Hospital Formulary Service Drug Information;
2. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will We pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.

And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to You before adding a Prescription Drug to the list.

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is a PPO)

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact Us to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after We make a decision regarding Pre-Approval or may choose to purchase the Prescription Drug prior to the decision being made. In either case, the Covered Person must pay for the Prescription Drug when it is dispensed. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

Supplies to Administer Prescription Drugs
We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and

services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Policy for treatments that are not Experimental or Investigational.]

Dental Care and Treatment
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

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

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a female Covered Person, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.

Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care

benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, We will cover charges for:

a) 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 Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:

a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

Therapy Services
Therapy Services mean services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

Subject to the stated limits, We cover the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

[Subject to Our Pre-Approval,] We cover the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
Coverage for Cognitive Rehabilitation Therapy is limited to 30 visits per Calendar Year.
g**.** *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.
Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a Covered Person’s ability to perform the ordinary tasks of daily living.
Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.
i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, physical therapy means treatment to develop a Covered Person’s physical function.

Coverage for Physical Therapy is limited to 30 visits per Calendar Year.

[We will reduce benefits by 50% with respect to charges for Cognitive Rehabilitation Therapy, Speech Therapy, Occupational Therapy or Physical Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]

j.*Infusion Therapy* - subject to Our Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. We will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any therapy services that are received under the Home Health Care provision, or to services provided while a Covered Person is confined in a Facility.

Preventive Care
We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, lead screening, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:
a) $750 per Covered Person for a Dependent child for the first year of life;
b) $500 per Covered Person for all other Covered Persons.

These charges are not subject to the Cash Deductible or Coinsurance.

Immunizations and Lead Screening
We will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

These charges are not subject to the Cash Deductible.

[Note to Carriers: Use this text for plans that are not used in conjunction with an HSA]

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.

Charges for screening by blood measurement for lead poisoning for children as specified in item a) above and all childhood immunizations as specified in item b) above are not subject to the Cash Deductible. Charges for 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 as specified in item a) above are subject to the Cash Deductible.

[Note to Carriers: Use this text for plans that are used in conjunction with an HSA]

Newborn Hearing Screening
We cover charges up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We cover charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Vision Screening
We cover vision screening for Dependent children, through age 17, to determine the need for vision correction. The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the Covered Person should undergo a vision examination. Such vision examination is not covered under this Policy.

Therapeutic Manipulation
[Subject to Our Pre-Approval,] We cover therapeutic manipulation up to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge. [**We will reduce benefits by 50% with respect to charges for Therapeutic Manipulation which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]**

Non-Biologically-based Mental Illnesses and Substance Abuse
We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse as those terms are defined in this Policy.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker.

The Covered Person must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit coverage for all treatment of Non-Biologically-based Mental Illnesses and Substance Abuse per Calendar Year to:

a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.

Subject to Our Pre-Approval, one or more of any unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits. **We will reduce benefits by 50% with respect to charges for Outpatient visits beyond the initial 20 visits which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**

We do not pay for Custodial Care, education, or training.

Transplant Benefits

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Heart-lung
g) Heart Valve
h) Pancreas
i) Intestine
j) Allogeneic Bone Marrow
k) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich]

l) Subject to Our Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **We will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**

l) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;

m) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, this Policy will cover the donor's costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

Surgical Treatment of Morbid Obesity

Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a Covered Person:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether case management may be available and appropriate. See the **Specialty Case Management** section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

[What We pay is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, Specialty Case Management or Centers of Excellence Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions
"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

By "covered professional charges for Surgery" We mean Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 am. to 9 pm. Eastern Time,] not including legal holidays.

Grievance Procedure
[Carriers must include the disclosure requirements set forth in N.J.A.C. 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
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-Emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or

c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an Emergency admission, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. We reduce what We pay for covered Hospital charges, by 50% if**:**

a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Hospital charges by 50%], if:
a) [ABC] is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

We require a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50%] if:

a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

[SPECIALTY CASE MANAGEMENT

Important Notice: No Covered Person is required, in any way, to accept a Specialty Case Management Plan recommended by [DEF].

Definitions
"Specialty Case Management" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b) While there are other covered services and supplies available under this Policy for the Covered Person's condition, the services and supplies We offer to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: We have sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or Us to be catastrophic.

Specialty Case Management Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop a Specialty Case Management Plan.

A Specialty Case Management Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Us].

The Specialty Case Management Plan includes:

a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; Covered Person; Covered Person's family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon Specialty Case Management treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any Calendar Year maximums.

Exclusion
Specialty Case Management does not include services and supplies that We determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

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

The amount of any charge which is greater than the ***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.

[Broken appointments.]

Services or supplies for which the Provider has not obtained a ***certificate of need*** or such other approvals as required by law.

Care and or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Policy.

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

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for behavior problems or learning disabilities.

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

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;

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

Services or supplies provided by one of the following members of Your ***family****:* Spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility***

Except as stated in the Newborn Hearing Screening provision, Services or supplies related to ***hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***herbal medicine***.

Services or supplies related to ***hypnotism***.

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Except as stated below, ***Illness*** **or** ***Injury****,* including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services****,* except as otherwise stated in this Policy.

Charges for ***missed appointments***.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

Non-prescription drugs or supplies, except

a) insulin needles and syringes and glucose test strips and lancets;
b) colostomy bags, belts and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

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

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

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.
EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Policy, provided he or she applies for coverage within 63 days of termination of the prior coverage. If coverage is not issued as a result of the application, the period from the Enrollment Date to the date the application is declined is excluded from the period without coverage.

In addition, this limitation does **not** affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Member: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the

Creditable Coverage was continuous to a date not more than 31 days prior to the Covered Person's Enrollment Date under this Policy, measured from the last date the Creditable Coverage was in force on a premium paying basis.

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

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

Services or supplies related to ***rest or convalescent cures***.

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care*** except:
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in this Policy.

Services or supplies*:*
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) for which the Covered Person has no legal obligation to reimburse the Provider;
e) provided by or in a government Hospital except as stated below, or unless the services are for treatment:

- of a non-service Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and

under military health coverage and who receive care in facilities of the Uniformed Services.

- provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student.

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

Travel to obtain medical treatment, drugs or supplies is not covered. In addition, We will not cover treatment, drugs or supplies that are unavailable or illegal in the United States.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Charges for ***third party requests*** for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.

Transplants, except as otherwise listed in this Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared: police actions; services in the armed forces or units auxiliary thereto.

Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction,

regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy.

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Member may be covered under this Policy and subsequently become covered by or eligible for coverage under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan**.** This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. This provision also allows us to coordinate benefits with what a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays**.** Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

Please note: The ONLY circumstances in which a person may be covered under both this Policy and under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan occur when a Covered Person is already covered under this Policy and subsequently becomes eligible for Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan.

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.

We will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

Allowed Charge: An amount that is not more than allowance 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 Covered Person is covered by this Policy and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

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.

For purposes of determining plans with which this plan can coordinate, 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 AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual policy, Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan is always the Primary Plan and this Policy is always the Secondary Plan. Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays or provides services or supplies first, without taking into consideration the existence of this Policy.

This Policy takes into consideration the benefits provided by Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. During each Claim Determination Period, this Policy will pay up to the remaining unpaid allowable expenses, but this Policy will not pay more than it would have paid if it had been the Primary Plan. The method this Policy uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

This Policy shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the 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 AC Plan and Secondary Plan is 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.

Primary Plan is 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 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 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 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 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.]

[Note to carriers: This paragraph should only be included in plans issued as HMO coverage.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

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

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

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

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

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

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

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

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

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

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

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

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Policy had been primary.

GENERAL PROVISIONS

AMENDMENT

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Policyholder of any of the Policyholder's interest under this Policy or by a Covered Person of any of his or her interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS

No clerical error nor programming or systems error by the Policyholder or by Us in keeping any records pertaining to coverage under this Policy will reduce a Covered Person's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Except as described in the **Premium Amounts** section, premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If any relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

CONFORMITY WITH LAW
Any provision of this Policy which, is in conflict with the laws of the State of New Jersey, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

GOVERNING LAW
This entire Policy is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE POLICY
There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a Covered Person covered under this Policy shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Policyholder.

If to the Policyholder: To the last address provided by the Policyholder on an enrollment or change of address form actually delivered to Us.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by You to Us. They are due on each premium due date. You may pay each Premium other than the first within 31 days of the premium due date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period, [this

Policy will continue in force without premium payment during the grace period and this Policy will end when the grace period ends.][coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.]

OFFSET
We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid premiums or claims payment previously made in error.

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.] The reinstated Policy shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the [Premium Rates and Provisions section of the Policy] [Policy's Schedule of Premium Rates]. We have the right to prospectively change Premium rates as of any of these dates:

a) any premium de date;
b) any date that the extent or nature of the risk under the Policy is changed:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

STATEMENTS
No statement will void the coverage, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by a Covered Person, and We furnish a copy to the Covered Person.

All statements will be deemed representations and not warranties.

TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section and to the provisions stated below.

We have the right to non-renew this Policy on the Policy Anniversary date following 180 days advance written notice to the Policyholder for the following reasons:

a) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
c) the Board terminates a standard plan or a standard plan option.

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end [when that period ends.][as of the end of the period for which premium has been paid.]
Termination by Request - If You want to replace this Policy with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)

d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

Also, Dependent coverage ends when the Policyholder's coverage ends.

THE CONTRACT

The entire Contract consists of:
[a the forms shown in the Table of Contents as of the Effective Date;
b)] the Policyholder’s application, a copy of which is attached to the Policy;
[c)] any riders, [endorsements] or amendments to the Policy.

WORKERS' COMPENSATION

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP OR CIVIL UNION ENDS

If Your marriage ends by legal divorce or annulment, or Your domestic partnership or civil union dissolves, the individual coverage for Your former Spouse ends. The former Spouse may convert to an individual contract during the conversion period. The former Spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Policy on the date this coverage ends. See **Exceptions** below.

Exceptions

No former Spouse may use this conversion right:

a) if he or she is eligible for Medicare;

b) if it would cause him or her to be excessively covered; This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after coverage under this Policy ends.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When We receive the notice, it will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS
Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as We receive due proof of the death to one of the following:

a) his or her estate;
b) his or her Spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When You file proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will determine to pay either the Covered Person or the Facility or the Practitioner.] You may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

We, at our expense, have the right to examine the insured. This may be done as often as reasonably needed to process a claim. We also has the right to have an autopsy performed, at Our expense.