Exhibit T

EXPLANATION OF BRACKETS FOR INDIVIDUAL HEALTH COVERAGE STANDARD PLANS AND APPLICATION

Text which is enclosed in brackets may *only* be modified as described in this Exhibit. Unless otherwise stated, carriers have the option to either include or not include the standard text.

Plans B - D and A/50

1) The name of the Carrier, specific dates, page numbers, deductible amounts or premium information may be inserted, as appropriate.
2) **Dividend** text on the face page and in the General Provisions should only be included by mutual carriers.
3) The definition of **Care Manager** should only be included by carriers that utilize such a provider.
4) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee only if the plan is issued through or in conjunction with a Selective Contracting Arrangement.
5) Omit the **definitions** of Network Provider, Out-Network Provider and Service Area for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
8) Omit the **PPO, POS and Appeals** sections for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.).
9) The **Coinsurance Cap** provision in the Benefit Deductibles, Copayments and Coinsurance section should be included in plans which are *not* issued through or in conjunction with a selective Contracting Arrangement. Omit the Coinsured Charge Limit provision.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Hospital Charges** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available *via rider* should include the text of the first item “j” in the Transplant section. Omit the second item “j” and item “k”. Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item “j” in the Transplant section. Include the second item “j” and item “k”.
12) Carriers that do not use centers of excellence should omit the **Centers of Excellence** section.
13) Carriers may elect to omit the **Provider Relationship** provision in the General provisions.

14) Omit the **Network and Out-Network Provider Relationship** provision in the General Provisions for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
15) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Policy-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.
16) Carriers that issue Point of Service plans may elect to allow a female Covered Person to use the services of a **network gynecologist** without PCP referral for stated services on an unlimited basis, or may limit the use of a network gynecologist without PCP referral to once per year. Include only the paragraph in the Point of Service provisions which reflects the elected option (not available with Plan A/50.)

Plans issued through or in conjunction with a **Selective Contracting Arrangement** (not available with Plan A/50.)

1) Include the following definitions:
- Network provider
- Out-Network Provider
- Service Area
2) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee.
3) Sample **Schedule** text is included for a PPO plan without copayments, a PPO plan with copayments, and a POS plan. For plans which use copayments, include only the categories of services to which a copay will apply. The dollar amounts of the copayments should be consistent with the copayment options available with the IHC HMO plan.
4) Include the Preferred Provider Organization section if the plan is a PPO. Include the name of the PPO wherever XYZ appears.
5) Include the Point of Service section if the plan is a POS. Include the name of the provider organization wherever XYZ appears.
6) Carriers issuing a PPO or a POS plan may include **Appeals Procedures**.
7) Include the **Coinsured Charge Limit** text in the Benefit Deductibles, Copayments and Coinsurance section. The Coinsurance Cap provision should be omitted.
8) Include the Network and Out-Network Provider relationship provision in the General Provisions.

[Plans issued with $1500 and $2250 High Deductible Options (that could be used in conjunction with an MSA)]For plans issued as high-deductible health plans that could be used in conjunction with an MSA or an HSA

1) Include only the **Schedule of Benefits** page which specifies the high deductible options **and which is labeled for use with a high-deductible health plan. Specify the specific dollar amounts for the deductible and maximum out of pocket amounts. Refer to N.J.A.C. 11:20-3.1 for permissible dollar amounts**. Omit all other schedules.

2) Include the **Benefit Deductibles, Copayments and Coinsurance** section which addresses the maximum out of pocket amount. Omit the corresponding section which addresses Coinsurance Cap/Coinsured Charge Limit.

HMO Plan

1) The name of the Carrier, specific dates, page numbers, copayment amounts or premium information may be inserted, as appropriate.
2) Wherever a series of terms are shown in brackets, select the term that is consistent with the carrier's terminology or practice.
3) Omit **Care Manager** definition if a care manager is not used.
4) Omit **Coinsurance** definition if prescription drugs are provided subject to a copayment.
5) Omit **Health Center** definition if not applicable.
6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
7) Carriers that require **that the person live, reside or work in the Service Area** as an eligibility criteria should include the bracketed text; and also include the bracketed termination text which addresses when a person no longer lives, resides or works in the Service Area.
8) Bracketed text is shown in the **Payment of Premiums-Grace Period** and **Termination of the Contract-Renewal Privilege** sections to accommodate termination as of the end of the grace period or as of the paid-to-date. Include appropriate bracketed text.
9) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Inpatient Hospital** section.
11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available via *rider* should include the text of the first item "23" in the Transplant section. Omit the second item "23" and item "24". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "23" in the Transplant section. Include the second item "23" and item "24".
12) The **Dispensing limits for prescription drugs** should be included in the Exclusions section by carriers that impose such limits.
13) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Contract-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.

Application

1) Omit those bracketed Instructions and bracketed text which do not apply.
2) Use the term Policy or Contract, as appropriate.
3) Use the term insured, subscriber or member, as appropriate.
4) If proof of full time student status or disability is not required to be attached to the application, the text which directs that proof be attached should be deleted.
5) In the Coverage section, carriers should include text which is consistent with the standard plan options that the carrier offers.
6) Omit the quarterly and/or semi-annual premium payment modes if those modes are not available.
7) The use of the Pre-Existing Conditions Statement is optional.
8) The statement regarding the selection of a PCP may be included, at the option of the carrier.
9) The statement regarding the option to elect coverage for ABMT should only be included by those carriers that make the benefit available via rider.
10) The variable text a carrier includes in the statement regarding termination in the event of falsified information should be consistent with the election of the carrier regarding termination as of the effective date, or immediately. Refer to item 15 of the explanation for Plans B - D and A/50, and item 13 of the explanation for the HMO plan.
11) Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.