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, 2023]]
[Note to Carriers: Omit Effective Date here if included below]

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]

[[Covered Person]: Jane Doe
Identification Number: 125689
Effective Date: January 1, 2023
[Product Name: XXXX]]

[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]]

[Include language taglines as required by 45 C.F.R. 155.205(c)(2)(iii)(A)]
Note to carriers: Carriers may place the taglines in the location the carrier believes most appropriate.

POLICY INDEX

SCHEDULE OF INSURANCE [PLAN A/50]

Calendar Year Cash Deductible

Preventive Care	NONE
Immunizations and	
Lead screening for children	NONE
Second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
Breastfeeding Support	NONE
All other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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:

Preventive Care	0%
Breastfeeding Support	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
All other Covered Charges	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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

SCHEDULE OF INSURANCE [PLAN B]

Calendar Year Cash Deductible

Preventive Care	NONE
Breastfeeding Support	NONE
Immunizations and	
Lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
All other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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:

Preventive Care:	0%
Breastfeeding Support	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
All other Covered Charges	40%

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

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

SCHEDULE OF INSURANCE [PLAN C]

Calendar Year Cash Deductible

Preventive Care	NONE
Breastfeeding Support	NONE
Immunizations and	
Lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
All other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person amount]

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. 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:

Preventive Care:	0%
Breastfeeding Support	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
All other Covered Charges	30%

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

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]]

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

SCHEDULE OF INSURANCE [PLAN D]

Calendar Year Cash Deductible

Preventive Care	NONE
Breastfeeding Support	NONE
Immunizations and	
Lead screening for children	NONE
Second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
All other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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:

Preventive Care	0%
Breastfeeding Support	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
All other Covered Charges	[20%] [10%]

Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

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

Copayment

Treatment, services and supplies given by a **Network** Provider

Preventive Care	NONE
Contraceptives [included under the Contraceptives Provision]	NONE
Breastfeeding Support	NONE
Physician Visits for all other Covered Charges	[dollar amount not to exceed $50]
Maternity Care (pre-natal visits)	NONE

Calendar Year Cash Deductible

Treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for services listed in the Copayment section

Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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.

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

Preventive Care:	0%
Network Contraceptives [included under the Contraceptives provision]	0%
Breastfeeding Support	0%
Prescription Drugs [Other than contraceptives] [including network contraceptives not covered under the Contraceptives provision]	[30%][0% for contraceptives]

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	

Oral and Maxillofacial Surgical Services	[20%]	
Orthodontic Treatment	[50%]]	
All other services and supplies:		
• if treatment, services or supplies are given by a Network Provider		10%
• if treatment, services or supplies are given by a Non-Network Provider		30%

Network Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the network maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

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

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

Copayment

Treatment, services and supplies given by a **Network** Provider

Preventive Care	NONE
Contraceptives [Included under the Contraceptives provision]	NONE
Breastfeeding Support	NONE
Physician Visits for all other Covered Charges	[dollar amount not to exceed $50]
Maternity Care (pre-natal visits)	NONE
Hospital Confinement	[an amount equal to 10 times the above copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar 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 services listed under the Copayment section and Prescription Drugs

Per Covered Person

Contraceptives [included under the Contraceptives provision]	NONE
Breastfeeding Support	NONE
All other Treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]

Per Covered Family

Contraceptives [included under the Contraceptives provision]	NONE
Breastfeeding Support	NONE
All other Treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs	[2 times per Covered Person dollar amount]]

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

[Preventive Care	NONE]
Immunizations and Lead screening for children	NONE
Second surgical opinion	NONE
All other Covered Charges	

Per Covered Person	[Dollar amount equal to 2 times the Network Deductible]
[Per Covered Family	[Dollar amount equal to 2 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. 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.

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

Preventive Care:	0%
Breastfeeding Support	0%
Network Contraceptives [included under the Contraceptives provision]	0%
Prescription Drugs [other than network contraceptives] [including network contraceptives not covered under the Contraceptives provision]	[30%][0% for contraceptives]

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]

All other services and supplies:

• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	20%

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

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person Maximum.]

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

SCHEDULE OF INSURANCE EXAMPLE EPO (with PCP Copayment)

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Copayment

Primary Care Provider Visits	[dollar amount not to exceed $50]
[Specialist Visits	an amount not to exceed $75]
Maternity Care (pre-natal visits)	NONE
Contraceptives [included under the Contraceptives provision]	NONE
Breastfeeding Support	NONE
[All [other] Practitioner Visits	an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]
[Hospital Confinement	[an amount equal to 10 times the above PCP copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]]

Calendar Year Cash Deductible

Treatment, services and supplies	
Preventive Care	NONE
Contraceptives [included under the Contraceptives provision]	NONE
Breastfeeding Support	NONE
Immunizations and Lead screening for children	NONE
Second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
[Prescription Drugs [other than contraceptives] [including network contraceptives not covered under the Contraceptives provision]	NONE, $250][NONE for contraceptives]
Visits subject to copayment	NONE
All other Covered Charges	
Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]

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. [Note, this Policy limits the amount a Covered Person is required to pay for each 30-day supply of a prescription. See the Prescription Drug Coinsurance Limit.]

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

Preventive Care:	0%
Contraceptives[included under the Contraceptives provision]	0%
Breastfeeding Support	0%
Primary Care Provider Visits	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
Treatment, services or supplies given by any other Network Provider	[20%, 30%, 40%, 50%][, **except as stated below]**

[Prescription Drugs [other than contraceptives] [including network contraceptives not covered under the Contraceptives provision] 50%] [See the Prescription Drug Coinsurance Limit below.][0% for contraceptives]

[Prescription Drugs [Other than contraceptives] [including network contraceptives not covered under the Contraceptives provision]

Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit][subject to the Prescription Drug Cost Sharing Limit][0% for contraceptives]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]

Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

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

[Prescription Drug Coinsurance Limit:	[$125] per 30 day supply]
[Prescription Drug Coinsurance Limit:	
Preferred Drugs	[$125] per 30 day supply
Non-Preferred Drugs	[$250] per 30 day supply]
[Prescription Drug Cost Sharing Limit	[$150][$250] per 30-day supply]

SCHEDULE OF INSURANCE **Example EPO High Deductible health plan text that could be used in conjunction with an HSA**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Calendar Year Cash Deductible

Preventive Care	NONE
Breastfeeding Support	NONE
Contraceptives,[included under the Contraceptives provision] except as stated below	NONE
Immunizations and Lead screening for children as detailed in the Immunizations and Lead Screening provision	NONE
Second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
•[Prescription Drugs and] Male sterilization or male contraceptives	[Minimum deductible to qualify as a high deductible health plan under Internal Revenue Code Section 223]
•All other Covered Charges	
[per Covered Person	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]
[per Covered Family	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]

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:

Preventive Care:	0%
Contraceptives [included under the Contraceptives provision]	0%
Breastfeeding Support	0%

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

V2500 – V2599 Contact Lenses	[50%
Optional lenses and treatments	50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	

Oral and Maxillofacial Surgical Services [20%]
Orthodontic Treatment [50%]]
All other Covered Charges [20%, 30%, 40%, 50%][,**except as stated below.]**
[Prescription Drugs [other than contraceptives]
[including network contraceptives not
covered under the Contraceptives provision] 50%] [See the Prescription Drug Coinsurance Limit below] [See the prescription Drug Cost Sharing Limit below] [0% for contraceptives]

[Prescription Drugs [other than contraceptives
[including network contraceptives not
covered under the Contraceptives provision]

Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]

[0% for contraceptives]

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:

[per Covered Person	[an amount permitted under Internal Revenue Code 223]
[per Covered Family	[an amount permitted under Internal Revenue Code 223]

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

[**Prescription Drug Coinsurance Limit**: $[125] per 30 day supply]

[Prescription Drug Coinsurance Limit:

Preferred Drugs	$[125] per 30 day supply
Non-Preferred Drugs	$[250] per 30 day supply]

[Prescription Drug Cost Sharing Limit Amount equal to the Minimum deductible to qualify as a high deductible health plan under Internal Revenue Code Section 223]

SCHEDULE OF INSURANCE EXAMPLE EPO (Example Catastrophic Plan – single coverage)

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Calendar Year Cash Deductible

Preventive Care	NONE
Breastfeeding Support	NONE
Contraceptives, [included under the Contraceptives provision]except as stated below	NONE
Immunizations and lead screening for children as detailed in the Immunizations and Lead Screening provision	NONE
Maternity Care (pre-natal visits)	NONE
Three physician visits per year:	NONE

- All other Covered Charges including male sterilization and male contraceptives

[per Covered Person [the greatest amount permitted by section 223(c)(2)(A)(ii)(I)]

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:: 0%

Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year: [the greatest amount permitted by section 223(c)(2)(A)(ii)(I)]

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

SCHEDULE OF INSURANCE (Continued) [PLANS A/50, B, C, D]
Daily Room and Board Limits

During a Period of Hospital Confinement

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

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.

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
- [Certain speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Therapeutic Manipulation]
- [Nutritional Counseling]
- [Certain Prescription Drugs][including Specialty Pharmaceuticals][and certain injectable drugs]
- [Services and/or prescription drugs to enhance fertility]
- [Complex Imaging Services]
- [V2500 – V2599 Contact Lenses]]

[For more information regarding the services for which We require Pre-Approval, consult our website at [www.xxx.com]]

[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 therapeutic manipulation per Calendar Year	30 visits
Charges for speech therapy per Calendar Year Note: This limit does not apply to speech therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for cognitive therapy per Calendar Year	30 visits
Charges for physical therapy per Calendar Year Note: This limit does not apply to physical therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for occupational therapy per Calendar Year Note: This limit does not apply to occupational therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for hearing aids for a Covered Person	one hearing aid per hearing impaired ear per 24-month period

[Non-Network Vision benefits for a Covered Person through the end of the month in which he or she turns age 19 are subject to the following limits:

Exam	$30 per 12-month period
Single Vision lenses	$25 per 12-month period
Bifocal lenses	$35 per 12-month period
Trifocal lenses	$45 per 12-month period
Lenticular lenses	$45 per 12-month period
Elective Contact lenses	$75 per 12 month period
Medically Necessary Contact lenses	$225 per 12 month period
Frames	$30 per 12 month period]

[Doula Services

[Global Maximum per pregnancy	[$0-$5,000 (amount to be determined by carrier)]]

[Standard Benefit
Visit limit

[Prenatal or Postpartum visits per pregnancy	[1-20 Visit(s) (Visit limit to be determined by carrier)]]
[Labor	[1-5 Visit(s) (Visit limit to be determined by carrier]]

[Enhanced Benefit
Visit limit

Prenatal or Postpartum visits per pregnancy	[1-20 Visit(s) (Visit limit to be determined by carrier)]
Labor	[1-5 Visit(s) (Visit limit to be determined by carrier]]
Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

The initial monthly premium rates, in U.S. dollars, for the coverage provided under this Policy are set forth on the [rate sheet] for this Policy for the effective date shown on the first page of this Policy. The monthly rates may be adjusted as explained in the Premium Rate Changes provision.

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.

Allowed Charge means an amount that is not more than [the lesser of:
• the allowance for the service or supply as determined by [Carrier] using the method specified below ; or
•]the negotiated fee schedule.

[For a plan that includes out of network benefits include the variable text above and the Carrier must specify the method used to determine the allowed charge and explain how a covered person may learn the allowed charge for a service the covered person may receive. If the plan includes out of network benefits include the following sentence.]

[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.]

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.

Annual open enrollment period means the designated period of time each year during which:

a) individuals are permitted to enroll in a standard health benefits plan and
b) individuals who already have coverage may replace current coverage with a different standard health benefits plans.

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

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

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

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

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.

[Brand Name Drug means: a) a Prescription Drug as determined by the Food and Drug Administration; and b) protected by the trademark registration of the pharmaceutical company which produces them.]

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.

[Complex Imaging Services means any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

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

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

Covered Charges are Allowed Charges for the types of services and supplies described in the **Covered Charges** section of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider[; unless otherwise covered as stated in the Policy]; 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." Covered Person does not include a Responsible Person, as defined.

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) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

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

Your " Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your foster child from the time the child is placed in the home,
d) Your step-child,
e) The child of your civil union partner,
f) the child of Your Domestic Partner, and
g) 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.

In addition to the Dependent children described above, any other child over whom You have legal custody or legal guardianship [or with whom You have a legal relationship or a blood relationship] may be covered to the same extent as 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.)
[Note to carriers: Text in brackets in the above paragraph may be deleted by carriers when selling coverage through the [Marketplace/ exchange or other appropriate term] that are concerned with covering such children in the absence of being able to apply the household requirement.]

[Please note that a Responsible Person is not eligible to enroll dependent children who qualify as dependents solely based on a legal relationship or blood relationship, without also having legal custody or legal guardianship.] [Also] [P][p]lease note], a Responsible Person is not required to have their dependent children reside in their household].
[Note to carriers: Carriers issuing policies on the Exchange would include the second sentence from the above paragraph. Carriers issuing policies outside the Exchange would include both sentences from the above paragraph.]

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, also referred to as neurodevelopmental disability or neurodevelopmentally disabled means a neurodevelopmental disorder which is referenced by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions.
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.

[Doula is an individual who meets the national birthing doula training requirements for birthing doula care. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula does not replace a trained, licensed medical professional, and cannot perform clinical tasks.]

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 and hearing aids. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

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

Effective Date means the date on which coverage begins under this Policy for the Policyholder, or the date coverage begins under this Policy for 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 covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). [An eligible person must be a U.S. Citizen, National or lawfully present in the United States.]

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 Use Disorder 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 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 nonaffiliated 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 in 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.

[Generic Drug means: a) a therapeutically equivalent Prescription Drug, as determined by the Food and Drug Administration; b) a drug which is used unless the Practitioner prescribes a Brand Name Drug; and c) a drug which is identical to the Brand Name Drug in strength or concentration,

dosage form and route of administration.] [A drug defined by the Food and Drug Administration as an "authorized generic drug" is not a generic drug.]

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 Health Condition; 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 The Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. 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 persons with Substance Use Disorder is also not a Hospital.

Illness or Ill means a sickness or disease suffered by a Covered Person or a description of a Covered Person suffering from a sickness or disease. Illness includes Mental Health Conditions and Substance Use Disorder.

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.

[Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from:

a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

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

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and 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.

With respect to treatment of Substance Use Disorder the determination of Medically Necessary and Appropriate shall use an evidence-based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services.

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

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

Mental Health Facility means a Facility which mainly provides treatment for people with Mental Health Conditions. 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.

Mental Health Condition means a condition which is referenced by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions.

[Network] Provider means a Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. You will have access to up-to-date lists of [Network] Providers.

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

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

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

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

[**Non-Preferred Drug** means a drug that has not been designated as a Preferred Drug.]

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

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

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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

[Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:

a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[**Participating Pharmacy** means a licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. 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.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

As used in the Breastfeeding Support provision, Practitioner also means a person who is an International Board Certified Lactation Consultant or a Lactation Counselor as defined in P.L. 2019, c. 343.

[As used in the Maternity Care provision, Practitioner also means a Doula.]

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.] [For information regarding the services for which We require Pre-Approval, consult our website at [www.xxx.com]]

[Preferred Drug means a Prescription Drug that; a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Covered Persons, upon request.

The list of Preferred Drugs will be revised, as appropriate.]

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

Preventive Care means:

a) Evidence based items or services that are rated “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the Covered Person;
b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;
c) Evidence–informed preventive care and screenings for Covered Persons who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for Covered Persons as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening, and Nicotine Dependence Treatment.

Primary Care Provider (PCP) means a Practitioner who is a Network provider who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished and who supervises, coordinates and maintains continuity of care for

[Covered Persons]. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

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, 5wigs 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. [Tribal Provider means those providers listed in 25 U.S.C. 1603, including the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization.]

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Provider [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."

Renewal Date means January 1 of the year immediately following the Effective Date of this Policy and each succeeding January 1 thereafter.

Resident means a person whose primary residence is in New Jersey. We will require a person to provide proof that his or her primary residence is New Jersey.

Responsible Person means a person who:

a) is the parent or legal guardian of multiple children who meet the definition of Dependent; and
b) applies to cover dependent children under this Policy without also covering the Responsible Person.

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.

Same Terms and Conditions means, with respect to the treatment of Mental Health Conditions and Substance Use Disorder, We cannot apply more restrictive non-quantitative limitations or more restrictive quantitative limitations to Mental Health Conditions and Substance Use Disorder, than We apply to substantially all other medical or surgical benefits.

Schedule means the **Schedule of Insurance** contained in this Policy.

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

Special enrollment period means a period of time that is no less than 60 days following the date of a triggering event during which:

a) individuals are permitted to enroll in a standard health benefits plan; and
b) individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plans.

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 diseases and hygiene)].

[Specialty Pharmaceuticals are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Pharmaceuticals. The list is also available on [Carrier's] website.

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 Use Disorder is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions. Substance Use Disorder includes substance use withdrawal.

Substance Use Disorder Facility means a Facility that mainly provides treatment for people with Substance Abuse problems. We will recognize such a Facility 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[.][;]
c) [accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or
d) credentialed by [Carrier].]

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.

Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

Telemedicine means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

The Joint Commission means the entity that evaluates and accredits or certifies health care organizations or programs.

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

Triggering event means an event that results in an individual becoming eligible for a Special Enrollment Period. Triggering events are:

a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the [Marketplace/ exchange or other appropriate term] .
b) The end of the plan or policy year under a non-calendar year group health plan or individual health insurance coverage if the plan or coverage is not renewed or the Eligible Person elects not to renew the coverage.
c) The date an Eligible Person's Practitioner confirms the Eligible Person is pregnant; the Eligible Person and the Eligible Person's Dependents qualify for a Triggering Event.
d) The last day or access to pregnancy-related coverage or access to health care services through coverage provided to the eligible person's unborn child.
e) The last date of coverage under medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act.
f) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
g) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
h) [The effective date of a [Marketplace/ exchange or other appropriate term] redetermination of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or no longer eligible for a subsidy or has a change in eligibility for cost sharing reductions] [*Note to Carriers, use this first clause for [Marketplace/ exchange or other appropriate term] plans*] [The effective date of a [Marketplace/ exchange or other appropriate term] redetermination that an Eligible Person is no longer eligible for a subsidy] *Note to carriers for off-[Marketplace/ exchange or other appropriate term] plans*.].
i) The date an Eligible Person gains or becomes a Dependent due to birth, adoption, placement for adoption, or placement in foster care or through a child support order or other court order; only the Eligible Person and new Dependents qualify for a triggering event.
j) The date an Eligible Person gains or becomes a Dependent due to marriage provided at least one spouse demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of marriage; only the spouses qualify for a triggering event.
k) The date an Eligible Person or his or her Dependent become newly eligible to enroll for [Marketplace/ exchange or other appropriate term] coverage because he or she newly satisfies the requirements under 45 CFR 155.305(a)(1) or (2) which generally pertains to citizenship, status as a national, lawful presence in the United States, and not being incarcerated.
l) The date an Eligible Person or his or her Dependent experience a decrease in income such that he or she is newly determined eligible for a subsidy provided he or she demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of the decrease in income.
m) The date NJFamilyCare determines an applicant who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
n) The date an Eligible Person and his or her Dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
o) The date an Eligible Person gains access to plans in New Jersey as a result of a permanent move provided the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.

p) The date of a [Marketplace/ exchange or other appropriate term] or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
q) The date of a determination that an Eligible Person's enrollment or non-enrollment in a qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, misconduct or inaction of the [Marketplace/ exchange or other appropriate term] or a non-[Marketplace/ exchange or other appropriate term] entity providing enrollment assistance or conducting enrollment activities.
r) The date the Eligible Person demonstrates to the [Marketplace/ exchange or other appropriate term] or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
s) The date the Eligible Person demonstrates to the [Marketplace/ exchange or other appropriate term] that he or she meets other exceptional circumstances as the [Marketplace/ exchange or other appropriate term] may provide.
t) One time per month for a person who gains or maintains status as an Indian, as defined by section 4 of the Indian Healthcare Improvement Act, allowing a new enrollment or a plan change through the [Marketplace/ exchange or other appropriate term] .
u) One time per month for a person who is or becomes a dependent of an Indian, as defined by section 4 of the Indian Healthcare Improvement Act, and who is enrolled or who is enrolling as a Dependent of an Indian, allowing a plan change at the same time as the Indian.
v) The effective date for an Eligible Person or Dependent under an Individual Coverage Health Reimbursement Arrangement known as ICHRA or a Qualified Small Employer Health Reimbursement Arrangement known as QSEHRA.
w) The date an Eligible Person moves to a different county in New Jersey provided the plans available from any carrier in the new residence county differ from those available in the prior residence county and the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the move.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

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

[**Walk-in Clinic** means a health care facility that provides limited medical care on a scheduled and unscheduled basis. The walk-in clinic may be located in, near or within a drug store, pharmacy, retail store or supermarket. The following are not considered a walk-in clinic: Ambulatory Surgical Center; emergency room; Hospital; outpatient department of a Hospital; Practitioner's office; Urgent Care Facility.]

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

[**You, Your and Yours** mean the Policyholder and/or any Covered Person or Responsible 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 coverage just for him/her self or may add one or more eligible Dependents for coverage. The possible types of coverage are listed below.

- **Single Coverage** - coverage under this Policy for only one person.
- **Family Coverage** - coverage under this Policy for You, Your Spouse and Your Dependent Child(ren)
- **Adult and Child(ren) Coverage -** coverage under this Policy for You and Your Dependent Child(ren).
- **[Single and Spouse] [Two Adults] Coverage** - coverage under this Policy for You and Your Spouse
- **Responsible Person and Children Coverage -** coverage under this Policy for the Responsible Person's Dependent Children or coverage for multiple children for whom the Responsible Person is the legal guardian.**–**
-

Who is Eligible to be Covered

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 [but must be a U.S. Citizen, National or lawfully present in the United States].
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 [but must be a U.S. Citizen, National or lawfully present in the United States].
Children – A Responsible Person's children who are Eligible Persons and who qualify as a Dependent, as defined in this Policy. **Note**: Children must be Residents [and must be U.S. Citizens, Nationals or lawfully present in the United States].

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 26 limit for eligible Dependents.

The child will stay eligible as long as the child is and remains unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Policy's age limit; b) the child became 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 [and a U.S. Citizen, National or lawfully present in the United States]. We reserve the right to require proof that such Covered Person is a Resident [and a U.S. Citizen, National or lawfully present in the United States].

Adding dependents to this Policy

Spouse - You may apply to add Your Spouse by notifying Us in writing. If Your application is made and submitted to Us within 60 days of Your marriage or documentation of domestic partnership or civil union, the Spouse will be covered. as of the first [or fifteenth] of the month following the date We receive the application.

In case of a court order, coverage of a spouse as required by a court order will be effective as of the date specified in the court order.

If You do not submit an application within 60 days of Your Spouse becoming eligible, You may apply to add coverage for Your Spouse during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Note: This Spouse provision does **not** apply to a Responsible Person.

Newborn Children - Except as stated below with respect to a newborn of a Responsible Person, We will cover Your newborn child for 60 days from the date of birth without additional premium. Coverage may be continued beyond such 60-day period as stated below:

You must give written notice to enroll the newborn child and any additional premium required for Dependent child coverage must be paid within 60 days after the date of birth for coverage to continue beyond the initial 60 days.

If the notice is not given and the premium is not paid within such 60-day period, the newborn child's coverage will end at the end of such 60-day period. You may apply for coverage for the child during an Annual Open Enrollment Period or during any applicable Special Enrollment Period.

Note: This Newborn Children provision applies to a newborn of a Responsible Person. However, any applicable premium for the newborn child must be paid for the newborn child to be covered from the date of birth.

Child Dependent - If You want to add coverage for an adopted child or foster child and You submit an application to Us within 60 days of the date of placement for adoption or placement in foster care, the adopted or foster child will be covered as of the date of placement for adoption or placement in foster care.

If You do not submit an application within 60 days of the placement for adoption or placement in foster care You may apply to add coverage for adopted or foster child during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Except as stated below with respect to a court order, if You want to add coverage for a child other than a newborn, adopted or foster child and You submit an application to Us within 60 days of the date the child is first eligible, the child will be covered as of the first [or fifteenth] of the month following the date We receive the application.

In case of a court order, coverage of a child dependent as required by a court order will be effective as of the date specified in the court order.

If You do not submit an application within 60 days of the date the child is first eligible, You may apply to add coverage for the child during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Note: This Child Dependent provision applies to an adopted or foster child of a Responsible Person.

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.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

In the case of Urgent Care or an Emergency, a Covered Person may go to a [XYZ Health Care Network] provider or a non-[XYZ Health Care Network] provider. If a Covered Person receives Urgent Care or care and treatment for an Emergency from a non-[XYZ Health Care Network] provider, and the Covered Person calls Us within 48 hours, or as soon as reasonably possible, so We will have the information necessary to 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 Providers 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.]

Network Provider Information

A Covered Person may identify network Providers using a provider directory that is available online or in paper format, or through an inquiry to Us made by phone or electronic means. If a Covered Person relies on the information We provide and receives services from a Provider We identified as a network Provider then the Covered Person's liability for services is limited to the network level copayment, deductible, coinsurance and maximum out of pocket. If We identified a Provider as a network Provider but the Provider was an out-of network provider, and the Covered Person uses the out-of-network Provider who provides services and bills and collects an amount above the network level copayment, deductible, coinsurance and maximum out of pocket, then We will reimburse the Covered Person for the excess amount paid.

[Note: Used only if coverage is offered as a PPO.]

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

Definitions
a) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. 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 Provider provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Provider refers the Covered Person to another Provider for such care, treatment, services, and supplies. [Network benefits are shown as [Tier 1] and [Tier 2].]
d) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Provider 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 have access to up-to date lists of [XYZ] PO Providers.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)
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 Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from the PCP. The Covered Person must obtain authorization from the 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 and 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, so We will have the information necessary to 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 Providers or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a 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.]

Network Provider Information
A Covered Person may identify network Providers using a provider directory that is available online or in paper format, or through an inquiry to Us made by phone or electronic means. If a Covered Person relies on the information We provide and receives services from a Provider We identified as a network Provider then the Covered Person's liability for services is limited to the network level copayment, deductible, coinsurance and maximum out of pocket. If We identified a Provider as a network Provider but the Provider was an out-of network provider, and the Covered Person uses the out-of-network Provider who provides services and bills and collects an amount above the network level copayment, deductible, coinsurance and maximum out of pocket, then We will reimburse the Covered Person for the excess amount paid.

[Note: Used only if coverage is offered as gated POS.]

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

Definitions

a) ***Primary Care Provider*** (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 Provider or any other Practitioner in the network provides care, treatment, services, and supplies to the Covered Person. [Network benefits are shown as [Tier 1] and [Tier 2].]
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.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)

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 applies to the services and 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, so We will have the information necessary to 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 Providers or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant

financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a 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.]

Network Provider Information

A Covered Person may identify network Providers using a provider directory that is available online or in paper format, or through an inquiry to Us made by phone or electronic means. If a Covered Person relies on the information We provide and receives services from a Provider We identified as a network Provider then the Covered Person's liability for services is limited to the network level copayment, deductible, coinsurance and maximum out of pocket. If We identified a Provider as a network Provider but the Provider was an out-of network provider, and the Covered Person uses the out-of-network Provider who provides services and bills and collects an amount above the network level copayment, deductible, coinsurance and maximum out of pocket, then We will reimburse the Covered Person for the excess amount paid.

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

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if referral is required.]

Definitions

a) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for benefits under this EPO policy.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. If the PCP obtains approval from 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 but have not been authorized by the PCP, the Covered Person will not be eligible for benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing]. For a discretionary change, the new PCP selection will take effect no more than 14 days following

the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

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

Emergency Services

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

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

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

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

Network Provider Information
A Covered Person may identify network Providers using a provider directory that is available online or in paper format, or through an inquiry to Us made by phone or electronic means. If a Covered Person relies on the information We provide and receives services from a Provider We identified as a network Provider then the Covered Person's liability for services is limited to the network level copayment, deductible, coinsurance and maximum out of pocket. If We identified a Provider as a network Provider but the Provider was an out-of network provider, and the Covered Person uses the out-of-network Provider who provides services and bills and collects an amount above the network level copayment, deductible, coinsurance and maximum out of pocket, then We will reimburse the Covered Person for the excess amount paid.

[Note: Used only if coverage is offered as Indemnity EPO.]

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if no referral is required.]

Definitions

a) ***Primary Care Provider*** (PCP) Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the [XYZ Network] for example, by providing referrals to specialists. Even if a PCP is selected, a Covered Person can choose any specialist he or she wants to use. [Whether or not a PCP is selected any office visit to a PCP who qualifies as a PCP is subject to the applicable PCP copayment.] [But if a Covered Person goes to a Practitioner other than a selected PCP a higher copayment will generally apply.] [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)
Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. 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 applicable Copayment, if any. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]
Emergency Services

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

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

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

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

Network Provider Information
A Covered Person may identify network Providers using a provider directory that is available online or in paper format, or through an inquiry to Us made by phone or electronic means. If a Covered Person relies on the information We provide and receives services from a Provider We identified as a network Provider then the Covered Person's liability for services is limited to the network level copayment, deductible, coinsurance and maximum out of pocket. If We identified a Provider as a network Provider but the Provider was an out-of network provider, and the Covered Person uses the out-of-network Provider who provides services and bills and collects an amount above the network level copayment, deductible, coinsurance and maximum out of pocket, then We will reimburse the Covered Person for the excess amount paid.

[Note: Used only if coverage is offered as Indemnity EPO.]

APPEALS PROCEDURE

[The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1 and External Appeals process. The text must address the specific appeals process and in-plan exception required by P.L. 2017, c.28.]

[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 and in certain cases of active treatment for up to 90 days, as described below.

In case of a Covered Person in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Covered Person's condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

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.

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

[The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

[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 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 HSA.]*

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before 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 [Tier 1] 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 [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before 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 [Tier 2] 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 [Tier 2] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before 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 [Tier 1] 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 [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, 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 the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
(*Use the above text if the Tier 1 deductible can be satisfied separately and allows a covered person to be in benefit for further Tier 1 covered charges and is also applied toward the satisfaction of the Tier 2 deductible.)*

[Family Deductible Limit
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.]

[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each Calendar Year.

When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the individual deductible limit amount in a calendar year. Once this Family Deductible is met in a Calendar Year, We provide coverage for all Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayment, for the rest of the Calendar Year.]

*[Note to carriers, use one of the above text for Family Deductible Limit for a plan that is **not** a high deductible health plan that could be used in conjunction with 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 HSA.]*

[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each Calendar Year.

Tier 1 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit**.** The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 1 individual deductible limit amount in a calendar year. Once this Tier 1 Family Deductible is met in a Calendar Year, We provide coverage for all Tier 1 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.

Tier 2 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 and Tier 2 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit**.** The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 2 individual deductible limit amount in a calendar year. Once this Tier 2 Family Deductible is met in a Calendar Year, We provide coverage for all Tier 1 and Tier 2 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.]

[Note to carriers: The above text may be used for plans that feature Tier 1 and Tier 2.]

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 [unless the Covered Person is entitled to a cost sharing reduction under Federal law and as a result of an eligibility change replaces a prior policy issued by Us with this Policy where both policies have the same classification of coverage and provided there has been no lapse in coverage between the previous policy and this Policy.] 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. 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.

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

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.

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services

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

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.

[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.

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

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network covered services and supplies for the remainder of the Calendar Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 2] Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.]
(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] covered services and supplies for the remainder of the Calendar Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for [Tier 1] Network or [Tier 2] Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] covered services and supplies for the remainder of the Calendar Year.
(*Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)*

[The Cash Deductible:
For Single Coverage Only
Each Calendar 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.

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.

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

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

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

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

[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a non-tiered high deductible health plan that could be used in conjunction with an HSA.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance.

The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider [as well as for treatment, services and supplies given by a [Tier 1] Network Provider that are applied to the [Tier 1 and Tier 2] Cash Deductibles]. Each Cash Deductible is shown in the Schedule.

The Cash Deductible:
For Single Coverage Only: [Tier 1]
Each Calendar Year, You must have Covered Charges that exceed the [Tier 1] per Covered Person Cash Deductible before We pay any benefits to You for those charges. The [Tier 1] 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 [Tier 1] per Covered Person Cash 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.

For Single Coverage Only: [Tier 2]
Each Calendar Year, You must have Covered Charges that exceed the [Tier 2] per Covered Person Cash Deductible before We pay any benefits to You for those charges. [Covered Charges applied to the [Tier 1] per Covered Person Cash Deductible also apply to this [Tier 2] per Covered Person Cash Deductible.] The [Tier 2] 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 [Tier 2] per Covered Person Cash 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.

Family Deductible Limit:
For Other than Single Coverage: [Tier 1]
The [Tier 1] per Covered Person Cash Deductible is **not** applicable. This Policy has a [Tier 1] 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 [Tier 1] 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.

For Other than Single Coverage: [Tier 2]
The [Tier 2] per Covered Person Cash Deductible is **not** applicable. This Policy has a [Tier 2] 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 [Tier 2] 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 that Covered Charges applied to the [Tier 1] per Covered Family Cash Deductible also apply to this [Tier 2] per Covered Family Cash Deductible.]

Maximum Out of Pocket:
The [Tier 1 and Tier 2] Per Covered Person and [Tier 1 and Tier 2] Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

For Single Coverage Only: [Tier 1]
In the case of single coverage, for a Covered Person, the [Tier 1] Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the [Tier 1] per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year.

For Single Coverage Only: [Tier 2]
In the case of single coverage, for a Covered Person, the [Tier 2] Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. [All per Covered Person Cash Deductible *plus* Coinsurance and Copayments applied to the [Tier 1] per Covered Person Maximum Out of Pocket also apply to this [Tier 2] per Covered Person Maximum Out of Pocket.] Once the [Tier 2] per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year.

For Other than Single Coverage: [Tier 1]
In the case of coverage which is other than single coverage, for a Covered Person, the [Tier 1] per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as [Tier 1] per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the [Tier 1] per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further [Tier 1] Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Family, the [Tier 1] Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as [Tier 1] per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the [Tier 1] per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further [Tier 1] Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the Calendar Year.

For Other than Single Coverage: [Tier 2]
In the case of coverage which is other than single coverage, for a Covered Person, the [Tier 2] per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as [Tier 2] per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the [Tier 2] per

Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further [Tier 2] Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year. [Note that amounts applied to the [Tier 1] per Covered Person Maximum Out of Pocket also apply to this [Tier 2] per Covered Person Maximum Out of Pocket.]

In the case of coverage which is other than single coverage, for a Covered Family, the [Tier 2] Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as [Tier 2] per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the [Tier 2] per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further [Tier 2] Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the Calendar Year. [Note that amounts applied to the [Tier 1] per Covered Family Maximum Out of Pocket also apply to this [Tier 2] per Covered Family Maximum Out of Pocket.]]

[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a tiered high deductible health plan that could be used in conjunction with an HSA.]

Benefits From Other Plans
The benefits We will pay will be affected by a Covered Person's being covered by or Eligible for Medicare or Entitled to Medicare. Read the provision **Effect of Medicare on an Individual Health Benefits Plan** to see how this works.

Impact of the Consolidated Appropriations Act (CAA) on Copayments, Deductible Amounts, and/or Coinsurance, Maximum Out of Pocket Amounts and Balance Billing

Emergency Services

If a Covered Person receives emergency services at a Hospital or independent freestanding emergency department, the Covered Person's liability for services rendered by an out-of-network Provider is limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

Except as stated below, the Covered Person's liability for post-stabilization emergency services is also limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. **Exception**: If **all** the following conditions are met, the out-of-network Provider may balance bill for the services:

a) The Covered Person's treating Practitioner determines that the Covered Person's medical condition would allow non-medical or non-emergency transportation to a network Provider located within a reasonable travel distance;
b) The Covered Person's treating Practitioner determines the Covered Person is in a condition to receive notice and provide informed consent; and
c) The out of network Provider provides the Covered Person with written notice as required by the CAA and obtains consent to balance bill.

Non-Emergency Services by Out-of-Network Practitioners at Network Facilities

If a Covered Person receives services at a network Hospital, including Hospital outpatient department, critical access Hospital or an Ambulatory Surgical Center, the Covered Person's liability for the following types of services will be limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

a) Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, neonatology
c) b) Services and supplies provided by assistant surgeons, hospitalists and intensivists Diagnostic services, including radiology and laboratory services
d) Services and supplies provided by an out-of-network Practitioner if there is no network Practitioner who can provide the service or supply at the Facility.

Air Ambulance

If a Covered Person receives covered air ambulance services the Covered Person's liability for such services rendered by an out-of-network air ambulance provider is limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

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 childbirth and newborn care coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by 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 does not require an Emergency Room Copayment]*.

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.

[Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay the Copayment shown on the Schedule of Insurance, 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 cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

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

[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 written home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Practitioner's Charges for Non-Surgical Care and Treatment
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.

Practitioner's Charges for Surgery

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

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.

Practitioner's Charges for Telehealth and/or Telemedicine
If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[Virtual Primary Care (VPC)

We cover virtual primary care (VPC) without deductible, copayment or coinsurance for the services listed below for [all] Covered Persons [18 years of age or older]. VPC is in addition to and does not replace coverage of in-person or Telemedicine or Telehealth visits to a Primary Care Provider.

[VPC must be provided by Practitioner, whose network contract with Us is to provide VPC by Telemedicine.]

Covered VPC Telemedicine services include:

a) General primary care consultations;
b) Preventive care screening and counseling;
c) Preventive care biometric review and analysis:
   – If a Covered Person will perform self-assessments, the Covered Person will be provided with a blood pressure cuff and heart monitor at no cost when the first VPC consultation is scheduled.
   – A Covered Person's results may be self-reported or reviewed by a VPC Telemedicine Practitioner by a remote device;
d) Consultations for non-emergency Illness or Injury, including prescriptions, when needed
e) Prescription drug coordination to encourage safe and appropriate use of medications
f) Follow-up care and coordination with Practitioners

The VPC telemedicine Practitioner can help a Covered Person identify network Practitioners for covered services ordered during a virtual consultation, including:

a) Diagnostic lab tests
b) Preventive care immunizations
c) In-person preventive care
d) In-person biometric screenings such as cholesterol and blood sugar testing

The applicable deductible, copayment or coinsurance will apply for services not provided by a VPC Telemedicine Practitioner and for any prescription drugs.

Note: Telemedicine consultations received from a Practitioner who is not a VPC Telemedicine Practitioner are not covered under this virtual primary care provision.]

[Walk-in Clinic Charges
We cover health care services provided through a Walk-in Clinic. Covered services include:
a) Scheduled and unscheduled visits for Illnesses and Injuries that are not visits to treat an Emergency;
b) Preventive care immunizations administered within the scope of the Walk-in Clinic's license;
c) Telemedicine and/or Telehealth consultations;
d) Individual screening and counseling services to address obesity or health diet as well as tobacco cessation.]

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.]

Mental Health Conditions or Substance Use Disorder
Except as stated below for the treatment of Substance Use Disorder, We cover treatment for Mental Health Conditions or Substance Use Disorder subject to the Same Terms and Conditions as apply to other medical or surgical benefits if such treatment is prescribed by a [Network] Provider [upon prior written referral by a Covered Person's Primary Care Provider].

We provide benefits for the treatment of Substance Use Disorder at Network Facilities subject to the following:

a) the prospective determination of Medically Necessary and Appropriate is made by the Covered Person’s Practitioner for the first 180 days of treatment during each Calendar Year and for the balance of the Calendar Year the determination of Medically Necessary and Appropriate is made by Us;
b) pre-authorization or Pre-Approval are not required for the first 180 days of inpatient and/or outpatient treatment during each Calendar Year but may be required for inpatient treatment for the balance of the Calendar Year;
c) concurrent and retrospective review are not required for the first 28 days of inpatient treatment during each Calendar Year but concurrent and retrospective review may be required for the balance of the Calendar Year;
d) retrospective review is not required for the first 28 days of intensive outpatient and partial hospitalization services during each Calendar Year but retrospective review may be required for the balance of the Calendar Year;
e) retrospective review is not required for the first 180 days of outpatient treatment including outpatient prescription drugs, during each Calendar Year but retrospective review may be required for the balance of the Calendar Year; and
f) If no Network Facility is available to provide in-patient services We shall approve an in-plan exception and provide benefits for in-patient services at a non-Network Facility.

The first 180 days per Calendar Year assumes 180 inpatient days whether consecutive or intermittent. Extended outpatient services such as partial hospitalization and intensive outpatient are counted as inpatient days. Any unused inpatient days may be exchanged for two outpatient visits.

Inpatient or day treatment may be furnished by any [Network] Provider that is licensed, certified or State approved facility, including but not limited to:

a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Facility;
e) a Substance Use Disorder Facility; or
f) a combination Mental Health Facility and Substance Use Disorder Facility.

Maternity Care

This Policy pays for pregnancies and associated maternity care the same way We would cover an Illness. Maternity care includes medically necessary prenatal and postpartum visits, laboratory and imaging services. [We also cover Doula care.]

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.

Breastfeeding Support Charges

We cover charges for lactation support, counseling and consultation and the rental or purchase of breastfeeding equipment as described in this provision, and subject to the requirements of P.L. 2019, c. 343. Coverage is provided in conjunction with each birth and continues for the entire period of breastfeeding. Charges covered under this provision are not subject to the Cash Deductible or Coinsurance or Copayment, if any.

We cover breastfeeding equipment as follows:

a) Purchase of single user breast pump which can be a double electric breast pump, or if requested by the Covered Person a manual pump. Such coverage does not require a prescription for the equipment nor are pre-authorization or evidence of medical necessity required. We also cover necessary repairs or replacement of the pump.
b) Rental or purchase of a multi-user breast pump, as recommended by a Practitioner who is a licensed health care provider. We may require a letter of medical necessity from a Practitioner.
c) Purchase of two breast pump kits; appropriate size breast pump flanges and other lactation accessories as recommended by a Practitioner.

We cover lactation counseling and lactation consultation without pre-authorization, referral or prescription as follows:

a) In person, one-on-one services at a hospital, office, home or any other location
b) Telephonic lactation assistance in addition to the services described in item a) above.
c) Group lactation counseling including educational classes and support groups, in addition to the services described in item a) above.

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.

Abortion

We cover the cost of abortion care, including the cost of medication or surgical abortion.

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.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

[We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under this 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 [physician visit to a non Specialist Doctor] [PCP 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.

Procedures and Prescription Drugs to Enhance Fertility
[Subject to Pre-Approval,] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Policy.

[We will reduce benefits by 50% with respect to charges to enhance fertility which are not Pre-Approved by Us provided that benefits would otherwise be payable under 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 cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the 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.

Donated Human Breast Milk
We cover pasteurized donated human breast milk for Covered Persons under the age of six months subject to the following conditions:
a) The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
b) The Covered Person's Practitioner issued an order for the donated human breast milk

We also cover pasteurized donated human breast milk as ordered by the Covered Person's Practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

a) A body weight below healthy levels determined by the Covered Person's Practitioner;
b) A congenital or acquired condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
c) A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the New Jersey Department of Health. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person's Practitioner.

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 contraceptives not covered under the Contraceptives provision] which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] Under this Policy We only cover 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.

[As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.]

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 [including Specialty Pharmaceuticals] 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 purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, [Carrier] will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Covered Person is responsible for the difference between the cost of the Brand Name Drug and the generic Prescription Drug. Exception: if the provider states "Dispense as Written" on the prescription the Covered Person will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A Covered Person must pay the appropriate Copayment for each Prescription Drug each time it is dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy]. The Copayment must be paid before the Policy pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is shown in the Schedule.

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Covered Person is insured. What [Carrier] pay[s] is subject to all the terms of the[Policy.]

[A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable Copayment for a Preferred Drug. [Carrier] will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Covered Person's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Covered Person.

[Carrier] shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Covered Person may follow the Appeals Procedure set forth in the Policy. In addition, the Covered Person may appeal a denial to the Independent Health Care Appeals Program.]

[The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy [or by a [Participating Mail Order Pharmacy]]; and

c) needed to treat an Illness or Injury Covered under this Policy.

Such charges will not include charges made for more than:

a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]

b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and

c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.]

[[Carrier] will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by [Carrier.]]

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

[[Carrier] will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a [Participating Mail Order Pharmacy] from charging the Covered Person for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Covered Person prior to dispensing the drug.]

[Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two separate amounts. The first shipment will be for a 15-day supply. The [Covered Person] will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the [Covered Person] takes the medication. The [Covered Person’s] cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the [Covered Person] does not wish to have a split fill of the medication, he or she may decline participation in the program. For those [Covered Persons] the Specialty Pharmacy will ship the full prescription amount and charge the [Covered Person] the cost share for the medication dispensed. Alternatively, the [Covered Person] may obtain the medication at a retail pharmacy.]

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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

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

Orally Administered Anti-Cancer Prescription Drugs As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Policy.

[We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs. We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Covered Person is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.]

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The Covered Person must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the Covered Person may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Policy. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Policy would have provided if the Covered Person had received intravenously administered or injected anti-cancer medications [from the Network or Non-Network Practitioner, as applicable] to determine which is more favorable to the Covered Person in terms of copayment, deductible and/or coinsurance. If the Policy provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment, deductible and coinsurance is more favorable to the Covered Person. If a Covered Person paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti-cancer medications the Covered Person will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

Contraceptives
We cover prescription contraceptives which require a Practitioner's prescription and which are approved by the United States Food and Drug Administration for that purpose In addition, We cover over-the-counter contraceptive drugs which are approved by the United States Food and Drug Administration for that purpose without a prescription.

a) We cover the following services, drugs, devices and procedures when obtained from or provided by network providers:
    1. Contraceptive drugs, devices or products approved by the United States Food and Drug Administration; or
    2. Therapeutic equivalents of contraceptive drugs, devices or products that are approved by the United States Food and Drug Administration.
    3. The medical necessity for contraceptive drugs, devices or products shall be as determined by the Covered Person's Practitioner.
b) Voluntary sterilization of a Covered Person whether male or female;
c) Patient education and counseling on contraception for a Covered Person;
d) Services related to the administration and monitoring of drugs, devices, products and services covered under this Contraceptives provision, including, but not limited to:
    1. Management of side effects;
    2. Counseling for continued adherence to a prescribed regimen;
    3. Device insertion and removal;
    4. Coverage of alternative contraceptive drugs, devices or products the Covered Person's practitioner determines are medically necessary; and
    5. Diagnosis and treatment services provided pursuant to or as a follow-up to services covered under this Contraceptive provision.

Coverage is provided for a twelve-month period.

[Except as stated below] Coverage under this Contraceptives provision is provided without the application of any deductible, coinsurance or copayment.

[Exception: With respect to a male Covered Person, coverage of male sterilization and male contraceptives is subject to the minimum deductible permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code. The deductible for this coverage is stated in the Schedule.]

[Note to Carriers: Include the Exception for High Deductible Health Plans.]

[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.]

Clinical Trial
The coverage described in this provision applies to Covered Persons who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Covered Person's practitioner is participating in the clinical trial and has concluded that the Covered Person's participation would be appropriate; or the Covered Person provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.
We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Covered Person participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Covered Person on the basis of the Covered Person's participation in the clinical trial.

Dental Care and Treatment
This Dental Care and Treatment provision applies to all Covered Persons.

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 later of:
    1. the date of the Injury; or
    2. the effective date of the[Covered Person's] coverage under this Policy.

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

[Dental Benefits

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19 when services are provided by a [Network] provider.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head

and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.

- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

<u>Diagnostic Services</u>

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) *Clinical oral evaluations once* every 6 months *
    1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
    2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
    3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
    4. Limited oral evaluations that are problem focused
    5. Detailed oral evaluations that are problem focused
b) Diagnostic Imaging with interpretation
    1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
    2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
    3. Additional films/views needed for diagnosing can be provided as needed.
    4. Bitewings, periapicals, panoramic and cephlometric radiographic images
    5. Intraoral and extraoral radiographic images
    6. Oral/facial photographic images
    7. Maxillofacial MRI, ultrasound
    8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
    1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
    2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report

3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
    1. fixed – unilateral and bilateral
    2. removable – bilateral only
    3. recementation of fixed space maintainer
    4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program

d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
    2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    3. Provisional crowns are not covered.
e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
g) Core buildup including pins
h) Pin retention
i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
j) Additional fabricated (custom fabricated/cast) and prefabricated post
k) Post removal
l) Temporary crown (fractured tooth)
m) Additional procedures to construct new crown under existing partial denture
n) Coping
o) Crown repair
p) Protective restoration/sedative filling

<u>Endodontic Services</u>

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection

n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening
    5. Osseous surgery
    6. Bone replacement graft – first site and additional sites
    7. Biologic materials to aid soft and osseous tissue regeneration
    8. Guided tissue regeneration
    9. Surgical revision
    10. Pedicle and free soft tissue graft
    11. Subepithelial connective tissue graft
    12. Distal or proximal wedge
    13. Soft tissue allograft
    14. Combined connective tissue and double pedicle graft
b) Non-Surgical Periodontal Service
    1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
    2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
    3. Full mouth debridement to enable comprehensive evaluation
    4. Localized delivery of antimicrobial agents
c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory

deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.

1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial
d) Denture adjustments –6 months after insertion or repair
e) Denture repairs – includes adjustments for first 6 months following service
f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
h) Precision attachment, by report
i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   2. Obturator prosthesis: surgical, definitive and modifications
   3. Mandibular resection prosthesis with and without guide flange
   4. Feeding aid
   5. Surgical stents
   6. Radiation carrier
   7. Fluoride gel carrier
   8. Commissure splint
   9. Surgical splint
   10. Topical medicament carrier
   11. Adjustments, modification and repair to a maxillofacial prosthesis
   12. Maintenance and cleaning of maxillofacial prosthesis
j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
   Covered services include: implant body, abutment and crown.
k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
   1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
   2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
   3. Considerations and requirements noted for single crowns apply
   4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
   5. Abutment teeth must be periodontally sound and have a good long term prognosis
   6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a) Extraction of teeth:
    1. Extraction of coronal remnants – deciduous tooth,
    2. Extraction, erupted tooth or exposed root
    3. Surgical removal of erupted tooth or residual root
    4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
    1. Oroantral fistula
    2. Primary closure of sinus perforation and sinus repairs
    3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
    4. Surgical access of an unerupted tooth
    5. Mobilization of erupted or malpositioned tooth to aid eruption
    6. Placement of device to aid eruption
    7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
    8. Surgical repositioning of tooth/teeth
    9. Transseptal fiberotomy/supra crestal fiberotomy
    10. Surgical placement of anchorage device with or without flap
    11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
    1. Incision and drainage of abcess - intraoral and extraoral
    2. Removal of foreign body
    3. Partial ostectomy/sequestrectomy
    4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
    1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.

2. Manipulation under anesthesia
3. Condylectomy, discectomy, synovectomy
4. Joint reconstruction
5. Services associated with TMJD treatment require prior authorization

o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
1. Repair of traumatic wounds – small and complicated
2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

<u>Orthodontic Services</u>

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.

- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program
e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

<u>Adjunctive General Services</u>

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for <u>additional</u> time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time

- Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
    - Office or Clinic maximum – 2 units
    - Inpatient/Outpatient hospital – 4 units
    - Skilled Nursing/Long Term Care – 2 units

d) Consultation by specialist or non-Primary Care Provider
e) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
    - For cases that are treated in a facility.
    - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
    - General anesthesia and outpatient facility charges for dental services are covered
    - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
    - Single administration
    - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouth guard covered once per year
j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as explained in the Explanation of Brackets. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a child under age 6]
For a Covered Person who is severely disabled or who is a child under age 6, 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, with respect to treatment of TMJ We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges

We cover charges made for mammograms provided to a 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 Covered Person– who is 40 years of age
b) one mammogram, every year, for a Covered Person age 40 and older; and
c) in the case of a Covered Person 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 Covered Person's Practitioner.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover charges for:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions is satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

See also the following benefit for Digital Tomosynthesis.

Digital Tomosynthesis Charges

We cover charges for digital tomosynthesis to detect or screen for breast cancer and for diagnostic purposes as follows:

a) When used for detection and screening for breast cancer in a Covered Person age 40 years and older, We cover charges for digital tomosysthesis as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.
b) When used for diagnostic purposes for a Covered Person of any age, We cover charges for digital tomosynthesis as a diagnostic service subject to the applicable copayment, deductible and coinsurance.

Colorectal Cancer Screening Charges

We cover charges made for colorectal cancer screening provided to a Covered Person age 45 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, hereditary 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 colorectal cancer screening is included under the Preventive Care 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. Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

For a Covered Person who has been diagnosed with autism or other Developmental Disability and who requires speech therapy to treat autism or other Developmental Disability, speech therapy means treatment of a speech impairment. Coverage for such treatment is addressed in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.

For a Covered Person who has been diagnosed with autism or other Developmental Disability and who requires occupational therapy to treat autism or other Developmental Disability, occupational therapy means treatment to develop a Covered Person’s ability to perform the ordinary tasks of daily living. Coverage for such treatment is addressed in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

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

For a Covered Person who has been diagnosed with autism or other Developmental Disability and who requires physical therapy to treat autism or other Developmental Disability, physical therapy means treatment to develop a Covered Person’s physical function. Coverage for such treatment is addressed in the Treatment of Autism and Other Developmental Disabilities provision.

[We will reduce benefits by 50% with respect to charges for Cognitive Rehabilitation Therapy, Speech Therapy, Occupational Therapy or Physical Therapy which are covered under this Therapy Services provision and 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 or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
We provide coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities. The coverage described below is subject to the Same Terms and Conditions as apply to other medical or surgical benefits.

If a Covered Person's primary diagnosis is autism or another Developmental Disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function.

a) occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
c) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. The therapy services covered under this provision are not subject to pre-Approval as may be required under the Therapy Services provision.

If a Covered Person's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Policy. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.

If a Covered Person:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other Developmental Disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a Covered Charge under this Policy. The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

[[**Gene-based, cellular and other innovative therapies (GCIT)]**

Covered services include GCIT provided by a Practitioner or Hospital.

This provision includes some terms which are explained below.

- A **gene** is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.
- **Molecular** means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.
- **Therapeutic** means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

a) Gene-based
b) Cellular and innovative therapeutics
c) Other innovative therapies

The services have a basis in genetic/molecular medicine and are not covered under the **Centers of Excellence** provision.

GCIT covered services include:

- [Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen).
  - siRNA.

- mRNA.
- microRNA therapies.]

[Facilities and Practitioners for gene-based, cellular and other innovative therapies

Covered Persons seeking GCIT services or procedures should contact Us for any needed assistance with locating Network Facilities and Practitioners who provide these services.

[Covered services also include:

- Travel and lodging expenses
  - If a Covered Person is using a GCIT Facility or practitioner that is 100 or more miles away from where the Covered Person lives, travel and lodging expenses are covered services for the Covered Person and a companion, to travel between home and the GCIT Facility or Practitioner

Coach class air fare, train or bus travel are examples of covered services]]

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.

These charges are not subject to the Cash Deductible or Coinsurance or Copayment, if any.

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 any Cash Deductible, Coinsurance or Copayment.

[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:
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
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.

Hearing Aids

We cover charges for medically necessary services incurred in the purchase of a hearing aid Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to Durable Medical Equipment will apply to the purchase of a hearing aid. The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

Vision Screening
We cover vision screening for Dependent children, through age 19, to determine the need for vision correction. The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the Covered Person should undergo a vision examination.

Vision Benefit
We cover the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19. We cover one comprehensive eye examination by a[n] [Network] ophthalmologist or optometrist in a 12 month period. [When purchased from a Network provider] We cover one pair of standard lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of standard frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

Therapeutic Manipulation
[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.]**

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants: Cornea, Kidney, Lung, Liver, Heart, Pancreas, Intestine, Allogeneic and Autologous Hematopoietic Stem Cell.

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 and other Facility 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 other Facility, 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 or other Facility 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.

[REQUIRED FACILITY STAY REVIEW

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

Notice of Facility Admission Required
Except as explained below for certain admissions to treat Substance Use Disorder, We require notice of all Facility 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 Facility charges as a penalty.

Pre-Admission Review
Except as explained below for certain admissions to treat Substance Use Disorder, all non-Emergency Hospital or other Facility 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-admission 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 the Covered Person's Practitioner must notify [ABC] and request a pre-admission 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 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 an admission, the authorization is valid for:
a) the specified Hospital or named Facility;
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 or other Facility, except in the case of a maternity admission.

Emergency Admission

Except as explained below for certain admissions to treat Substance Use Disorder, [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 or other Facility
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review

Except as explained below for certain admissions to treat Substance Use Disorder, 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 or other Facility 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 or other Facility admission. And [ABC] may contact the Covered Person's Practitioner or Hospital or other Facility 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 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

Except as explained below for certain admissions to treat Substance Use Disorder, in the case of a non-Emergency admission, as a penalty for non-compliance. We reduce what We pay for covered Facility charges, by 50% if**:**

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

In the case of an Emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Facility 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 or his or her Practitioner does not request a continued stay review; or
c) the Covered Person or his or her Practitioner 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 or other Facility admission, if a Covered Person stays in the Hospital or other facility longer than [ABC] authorizes, We reduce what We pay for covered 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.]

Admissions for the Treatment of Substance Use Disorder – Network Only

This section applies during the first 180 days of network treatment per Calendar Year whether the treatment is inpatient or outpatient. Thereafter, inpatient treatment of Substance Use Disorder is subject to the above provisions governing Hospital and other Facility admissions.

If a Covered Person is admitted to a Facility for the treatment of Substance Use Disorder, whether for a scheduled admission or for an emergency admission, the Facility must notify Us of the admission and initial treatment plan within 48 hours of the admission.

We will not initiate continued stay review, also known as concurrent review, with respect to the first 28 days of the inpatient stay. Continued stay review may be required for any subsequent days, but not more frequently than at two-week intervals. If We determine continued stay is no longer Medically Necessary and Appropriate We shall provide written notice within 24 hours to the Covered Person and his or her Practitioner along with information regarding appeal rights.

[REQUIRED PRE-SURGlCAL 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 Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) Substance Use Disorder
l) Mental Health Condition
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 except as otherwise stated in this Policy.

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

Extraction of teeth, except as otherwise stated in this Policy.

Services or supplies for or in connection with:
a) except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;

b) except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19 eyeglasses or lenses of any type; this exclusion does not apply to 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*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

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

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

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

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

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***.

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;
c) as stated in this Policy for food and food products for inherited metabolic diseases; and
d) as stated in this Policy for contraceptives.

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.

[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***

a) Charges to administer a Prescription Drug.

b) Charges for:

- immunization agents [unless the immunization is otherwise covered under this Policy, such as immunizations to help prevent influenza, and is administered at the pharmacy[. Refer to [carrier website] for the list of immunizations that may be administered at the pharmacy.],
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.

e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed

g) Charges for drugs, except insulin and contraceptives, which can be obtained legally without a Practitioner's prescription.

h) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:

- a Hospital
- a rest home

- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Use Disorder Facility
- a Mental Health Facility
- a convalescent home
- a nursing home
  or similar institution
- a provider's office.

i) Charges for:

- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for topical dental fluorides.

k) Charges for any drug used in connection with baldness.

l) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the

m)Covered Person taking part in the commission of a felony.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] [is/are] legally required to pay it, [Carrier] will.

q) Charges for drugs covered under Home Health Care; or Hospice Care section of the [Policy.]

r) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **Exception**: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

s) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

[t) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.]

u) Drugs when used for cosmetic purposes. This exclusion is not applicable to Covered Persons with a medically diagnosed congenital defect or birth abnormality who have been covered under the policy from the moment of birth.

v) Drugs used solely for the purpose for weight loss.

[w) Life enhancement drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

x) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.]

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.

[Telephone consultations except as stated in the Practitioner's Charges for Telehealth and/or Telemedicine provision.]

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 except as otherwise covered under this Policy as Preventive Care.

Services or supplies received as a result of a ***war***, or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards

incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area

Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the 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 Covered Person may be covered under this Policy and subsequently become covered by or eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan**.** This provision 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 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 coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan.

Note: See the separate provision addressing Medicare.

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 a Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) 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;
g) Medicare.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual policy, 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. 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 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." An HMO, and Exclusive Provider Organization (EPO) are examples of network only plans that could use a fee schedule. 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 the HMO or EPO or other plan 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, EPO 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, "HMO" refers to a health maintenance organization plan, and "EPO" refers to Exclusive Provider Organization.

<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 or EPO plan that does not allow for the use of non-network providers except in the event of Urgent Care or Emergency Care and the service or supply the Covered Person receives from a non-network provider is not considered as Urgent Care or Emergency Care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or 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 or EPO and Secondary Plan is an HMO or EPO

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

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

EFFECT OF MEDICARE ON AN INDIVIDUAL HEALTH BENEFITS PLAN

Eligible for Medicare and Entitled to Medicare
There are three ways a person may become eligible for Medicare. The most common eligibility is the first of the month in which a person attains age 65. A person may also become eligible for Medicare due to disability following a determination of disability by the Social Security Administration. Lastly, a person may become eligible for Medicare due to End Stage Renal Disease (ESRD).

Eligibility for Medicare means a person meets the requirements to be covered under Medicare. It does not mean the person has enrolled for Medicare.

A person who is Eligible for Medicare has the opportunity to enroll for Medicare Parts A and B and may also enroll in Medicare Part D and may elect to buy a Medicare Supplement Plan. Alternatively, a person may enroll for Medicare Parts A and B and may elect coverage under a Medicare Advantage plan. For the purpose of this provision, **Eligible for Medicare** means a person is eligible for premium-free coverage under Medicare Part A.

A person who enrolls for Medicare Part A and Part B or just Part A is **Entitled to Medicare. Entitled to Medicare** means the person has coverage under at least one part of Medicare.

Individual is Covered Under an Individual Health Benefits Plan and Later Becomes Eligible for Medicare
Since individual health benefits plans are guaranteed renewable, We do not terminate a Covered Person's coverage when the Covered Person becomes Eligible for Medicare. The guaranteed renewability protection under Federal and State law allows renewal of the identical individual health benefits plan even after the Covered Person is eligible for Medicare. However, the payment of benefits may change significantly.

Individual health benefits plans are not Medicare Supplement Plans and do not operate as Medicare Supplement Plans. Also note that the Medicare coordination process that applies to group plans does not apply to individual plans.

Please note: The ONLY circumstance in which a person may be covered under both this Policy and Medicare occurs when a Covered Person is already covered under this Policy and subsequently becomes eligible for Medicare.

Eligibility Due to Age
We will assume the Covered Person enrolled for Medicare Parts A and B when the person was first eligible for premium-free Medicare Part A whether or not the person actually enrolls for Medicare. The benefit payable under this Policy will equal the applicable cost sharing under Medicare Parts A and B for the services and supplies received. For example, if Medicare Part B would have paid 80% of the Medicare allowed charge, the benefit payable under this Policy would be the cost sharing of 20% of the Medicare allowed charge. This Policy will not pay benefits that

would have been payable by Medicare Parts A or B if the person had enrolled for Medicare Parts A and B.

Eligibility due to ESRD and Disability
If the person has not enrolled for Medicare Parts A and B this Policy will continue to pay benefits without consideration of Medicare. If the person has enrolled for Medicare Part A or Medicare Parts A and B this Policy will pay benefits as secondary to Medicare.

If the Covered Person has enrolled for Medicare Part A or Medicare Parts A and B the benefit payable under this Policy will equal the applicable cost sharing under Medicare Parts A and B for the services and supplies received.

Individual is Entitled to Medicare and Applies for an Individual Health Benefits Plan
Both the anti-duplication provisions of the Social Security Act and the New Jersey Individual Health Insurance Reform Act prohibit Us from issuing an individual health benefits plan to an individual who is entitled to Medicare, even if the individual has enrolled only for Medicare Part A.

The Covered Person must respond to Our inquiries regarding whether they are Eligible for Medicare or Entitled to Medicare. When a Covered Person turns 65 We will assume the Covered Person is Eligible for Medicare and pay secondary benefits as set forth in this section unless the Covered Person provides written documentation that proves the Covered Person is not Eligible for Medicare. If Our records show that the Covered Person is Entitled to Medicare due to disability or ESRD We pay secondary benefits as set forth in this section unless the Covered Person provides written documentation that proves they are not Entitled to Medicare and thus Our records are incorrect.

If an individual provides misinformation on the application regarding Medicare entitlement and is issued an individual health benefits plan, upon discovery of the misstatement We will take action as explained in the **Incontestability of this Policy** or **Clerical Error – Misstatements** provision, as appropriate.
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SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Covered Person'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.

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

<u>The following paragraph only applies to Covered Persons who are NOT recipients of the premium tax credit and Covered Persons who are recipients of the premium tax credit but have not paid at least one full month's premium during the calendar year</u>

Premiums are due on each premium due date. Each premium other than the first must be paid within 31 days of the premium due date. Those days are known as the grace period. Premiums must be paid from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. Premiums must be paid for the time the Policy stays in effect. 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.]

<u>The following paragraph only applies to Covered Persons who ARE recipients of the premium tax credit who have paid at least one full month's premium during the calendar year</u>

Premiums are due on each premium due date. While each premium is due by the premium due date there is a grace period for each premium other than the first that runs for 3 consecutive months from the premium due date. We will pay all appropriate claims for services and supplies received during the first month of the grace period. We will pend the payment of claims for services beyond the first month through the end of the 3 month grace period. We will send You a notice if payment

is not made by the premium due date and if payment is not made, the Policy will end 30 days following the date of the notice. Premium must be paid for the time coverage stays in effect. We will notify the Federal Department of Health and Human Services if the required premium is not paid by the premium due date. We will also notify the Providers for the pended claims that the claims may be denied.

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 Covered Person 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 referenced in the Premium Rates section of the Policy. We have the right to prospectively change premium rates as of any of these dates:

a) any premium due 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.

RENEWAL PRIVILEGE – TERMINATION

All periods of insurance hereunder will begin at 12:01 a.m. and end at midnight Eastern Standard Time.

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

We have the right to non-renew this Policy on the Renewal Date following written notice to the Policyholder for the following reasons:

a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
b) subject to 90 days advance written notice, 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 Covered Persons or persons who may become eligible for coverage;
c) subject to 90 days advance written notice, the Board terminates a standard plan or a standard plan option; [or]
d) [with respect to coverage issued through the [Marketplace/ exchange or other appropriate term] , decertification of the plan].

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to [Marketplace/ exchange or other appropriate term] requirements, if any.

<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any premium is not paid by the end of its grace period, the Policy will end as described in the Grace Period provision.

<u>Termination by Request</u> - If You want to end this Policy because you are replacing 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 midnight. on the day before the effective date of the new Plan and any unearned premium will be refunded.

If You want to end this Policy for any other reason, You may write to Us, in advance of the requested termination date, to ask that the Policy be terminated. The Policy will end on the date requested.

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

a) Premiums have not been paid in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as described in the Grace Period provision.)
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 midnight on the day before the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)

e) With respect to a catastrophic plan, the date of a [Marketplace/ exchange or other appropriate term] redetermination of exemption eligibility that finds the Covered Person is no longer eligible for an exemption, or until the end of the plan year in which the Covered Person attains age 30, whichever occurs first.

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 at midnight on the date the Dependent is no longer a Dependent, as defined in the Policy However, for a Dependent child who is no longer a dependent due to the attainment of age 26 coverage ends at midnight on the last day of the month in which the Dependent attains age 26. Also, Dependent coverage ends when the Policyholder's coverage ends.

THE CONTRACT

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance.

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

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

If a notice or proof is sent later than 90 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. [[Carrier] uses reimbursement policy guidelines that were developed through evaluation and validation of standard billing practices as indicated in the most recent edition of the Current Procedural Terminology (CPT) as generally applicable to claims processing or as recognized and utilized by Medicare. [Carrier] applies these reimbursement policy guidelines to determine which charges or portions of charges submitted by the Facility or the Practitioner are Covered Charges under the terms of the Policy.]

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 have the right to have an autopsy performed, at Our expense.