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.

[CARRIER]
INDIVIDUAL BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN
As required by P.L. 2001, c. 368

[Policy] Term. The [Policy] takes effect on [_____], the [Policy] Effective Date. The term of this [Policy] starts on Your Effective Date, and may be renewed each year on the Anniversary Date, subject to the terms and conditions of this [Policy].

[Premium Due date: [ ]]

THIS POLICY DOES NOT PROVIDE COMPREHENSIVE MAJOR MEDICAL COVERAGE

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

TABLE OF CONTENTS

Section **Page**

DEFINITIONS

The words shown below have specific meanings when used in this [Policy]. Please read these definitions carefully. Throughout the [Policy], these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this [Policy].

ACCREDITED SCHOOL. A school approved 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.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol. Alcoholism does **not** include abuse of or addiction to drugs. Please see the definition of Substance Abuse.

AMBULANCE. A certified vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this [Policy] and each succeeding yearly date thereafter.

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

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.] *[Note to carriers: Include if issued as a managed care plan that uses care managers.]*

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this [Policy] pays any benefits for such charges. The Deductible is shown in the Coverage Schedule. The Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges. See the "Cash Deductible" provision of this [Policy] for details.

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

COINSURANCE. The percentage of a Covered Charge that must be paid by You, as shown in the Coverage Schedule. Coinsurance does **not** include Cash Deductibles, Copayments or Non-Covered Charges.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges. **[**You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.]

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

[COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in this [Policy]. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide wellness care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this [Policy]. Read the entire [Policy] to find out what We limit or exclude.] *[Note to carriers: Include if issued as a non HMO-based plan. HMO based plans should use the Covered Services or Supplies text that follows.]*

COVERED PERSON. An Eligible Person who is insured under this [Policy]. Throughout this [Policy], Covered Person is often referred to using "You" and "Your."

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in this Contract. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide wellness care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) Furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire Contract to find out what We limit or exclude. *[Note to carriers: Include if issued as an HMO-based plan.]*

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

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

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

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

DEPENDENT.
a) Your:
1) spouse;
2) unmarried Child who is Your own issue, Your legally adopted Child, or Your step-Child until the Child's 19th birthday. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Policy provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, and who is enrolled as a full-time student at an Accredited School (We may ask for periodic proof that the Child is so enrolled); and

4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this [Policy]'s age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this [Policy]'s age limit;
3) the Child became insured before the Child reached this [Policy]'s age limit, and stayed continuously insured until reaching such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his or her support and maintenance. You have 31 days from the date the Child reaches this [Policy]'s age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not 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.

DIAGNOSTIC SERVICES. 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) EKG's, EEG's, and other electronic diagnostic tests.

Except as allowed under the Wellness benefit provision of this [Policy], 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. Our sole right to make a decision or determination. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, Hospital-type beds, walkers, and wheelchairs.

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 Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this [Policy] for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

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

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies, including treatments, procedures, Hospitalizations, drugs, biological products or medical devices, which We Determine are:
a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

We will also not cover any technology or any Hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

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

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:
1) any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (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:
-The American Hospital Formulary Service Drug Information; or
-The United States Pharmacopeia Drug Information.
recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2) conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3) demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4) proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5) proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:
a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this [Policy], the aggregate of the periods of Creditable Coverage is 18 or more months;

b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or Hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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.

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

GROUP HEALTH BENEFITS PLAN. A [Policy], program or plan that provides medical benefits to a group of two or more individuals.

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

HEALTH BENEFITS PLAN. Any Hospital and medical expense insurance [Policy]; health service corporation contract; Hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this [Policy], 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 Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally Injured. We will recognize it 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 ;

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

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. 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, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You or a description of You suffering from a sickness or disease.

INJURY (OR INJURED.) All damage to a Covered Person's Body and all complications arising from that damage or a description of You suffering from such damage.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, or Injury;
c) in accordance with generally accepted medical practice;
d) not for Your convenience;
e) the most appropriate level of medical care that You need; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

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

[[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.] You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.] *[Note to carriers: Include if issued as a managed care plan.]*

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

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

NON-COVERED CHARGES. Charges which do not meet Our 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. Utilization Review Penalties are also Non-Covered Charges.

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not **a** [Network] [Participating] Provider.] *[Note to carriers: Include if issued as a managed care plan.]*

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

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

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such Outpatient settings.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. § 1002(16)(B)). That is:
a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

[POLICY]. This agreement, [the [Policy] Coverage Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

[POLICY]HOLDER. The person who purchased this [Policy].

[POLICY] TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this [Policy] is renewed, each one-year period thereafter.

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

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this [Policy] starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

Complications of pregnancy are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. Complications of pregnancy are defined at N.J.A.C. 11:1-4.3

See the section of this [Policy] called "Pre-Existing Condition Limitations" for details on how this [Policy] limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this [Policy].

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

[**PRIMARY CARE PHYSICIAN (PCP).** A [Network] [Participating] Provider who is a Practitioner specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.] *[Note to carriers: Include if issued as a managed care plan that uses a PCP.]*

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

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the lesser of:
a) The reasonable and customary charge for the service or supply as set forth in the Prevailing HealthCare Charges System (PHCS) data using the 80th percentile; or
b) The negotiated fee, if any, between [Carrier] and the Provider for the service or supply.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people.

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

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

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital.

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

[SPECIALIST PRACTITIONER. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.] *[Note to carriers: Include if issued as a managed care plan that uses these terms.]*

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

SURGERY.
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; or
c) Reasonable and Customary pre-operative and post-operative care.

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have 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;
b) approved for its stated purpose by Medicare.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

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

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The [Policy]holder and / or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A [Policy]holder who completes an application for coverage may elect one of the types of coverage listed below:

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

WHO IS ELIGIBLE

a) **The [Policy]holder** - You, if You are an Eligible Person, except as provided below.
b) **Spouse** - Your Spouse, who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **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; and except as provided below.

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

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **Eligibility If You Are Covered Under Another Individual [Policy]** - You and/or Your Dependents are eligible for coverage under this [Policy] if this [Policy] replaces another individual [Policy] under which You and/or Your Dependents are covered. You may request termination of the replaced individual [Policy] pursuant to the termination provisions of that plan. We may require proof that the other coverage has been terminated.
b) **Eligibility If You Are Eligible for Coverage Under a Group Health Benefits Plan** - You and/or Dependents may be eligible for coverage under this [Policy] only during the open enrollment period which occurs each year during the month of November, for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS [POLICY]

a) **Spouse** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, he or she will be covered from the date of his or her eligibility.

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

b) **Newborn Dependent** - A Child born to You or Your Spouse while this [Policy] is in force will be covered without additional premium for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid. [[You should notify Us of the birth of the newborn Child as soon as possible.].

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

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

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

COVERAGE SCHEDULE

Copayments:

• Hospital Confinement	$500 per Covered Person per Period of Confinement
• Inpatient Care for Biologically Based Mental Illness	$500 per Covered person per Period of Confinement
• Outpatient and Ambulatory Surgery	$250 per Covered Person per Surgery
• Emergency Room Services	$100 per Covered Person per Visit
• Outpatient Physical Therapy	$20 per Covered Person per Visit
• All other Covered Services and Supplies	None

[**NOTE**: You may be required to pay an amount in excess of the above Copayments if the Provider's bill exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: This text should be included when there is a possibility of balance billing.]*

Deductible:

• Wellness benefit	$50 per Covered Person per Calendar Year
• All other Covered Services and Supplies	None

[Policy]holder Coinsurance:

• Alcohol and Substance Abuse Inpatient and Outpatient For Inpatient Care, Coinsurance applies *after* the payment of the Copayment	30%
• Biologically Based Mental Illness Outpatient Care	30%
• Wellness Benefit Coinsurance applies *after* the payment of the Deductible	20%
• All other Covered Services and Supplies	NONE

Coverage Limits:

• Hospital Confinement	90 days per Covered Person per Calendar Year
• Biologically Based Mental Illness	
Inpatient Care	90 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per Calendar Year
• Alcohol and Substance Abuse	
Inpatient Care	30 days per Covered Person per Calendar Year
Outpatient Care	30 visits per Covered Person per

Calendar Year

- Physical Therapy (Outpatient) — 30 visits per Covered Person per Calendar Year
- All Other — Unlimited

Daily Room and Board Limits
During a Period of Hospital Confinement:

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

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

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

Maximum Benefits

- Outpatient diagnostic tests — $500 per Covered Person per Calendar Year
- Wellness benefit — $600 per Covered Person per Calendar Year
- Practitioner visits for injury or sickness — $700 per Covered person per Calendar Year
- All other services and supplies: — Unlimited

PREMIUM RATES AND PROVISIONS

PREMIUM RATES

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this [Policy] are [shown in the [Policy]'s Schedule of Premium Rates]:

For Single Coverage.	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage.	[$]
For Husband and Wife Coverage.	[$]

We have the right to prospectively change the Premium rate set forth in this [Policy] as described below.

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the [Policy].] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the [Policy] is in force in order for this [Policy] to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period this [Policy] will continue in force during the grace period and this [Policy] will end when the grace period ends. However, We may deduct the amount of premium due for the period this [Policy] stays in force during the grace period from the amount of any benefit to be paid for Covered Charges incurred during the grace period.

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 shown in this [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.

[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 Practitioner based on a breach of contract by the Practitioner, a determination of fraud, or where Our medical director is of the opinion that the Practitioner 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 Practitioner for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated Practitioner. In case of pregnancy of a Covered Person, coverage of services for the terminated Practitioner 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 Practitioner 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 Practitioner 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 Practitioner 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 Practitioner was employed by or under contact with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the Practitioner while the Practitioner was employed by or under contract with Us.

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

We shall not continue services in those instances in which the Practitioner has been terminated based upon the opinion of Our medical director that the Practitioner 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 Practitioner. The determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a Practitioner 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 Practitioner 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 Practitioner and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.]

*[**Note**: Include this text if the plan is issued as a managed care plan]*

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 [Carrier's] primary care physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

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

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

BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE

Cash Deductible: Each Calendar Year, You must have Covered [Charges] [Services or Supplies] that exceed the Deductible applicable to wellness benefits before We [pay any benefits] [cover services or supplies] for those charges. The Deductible is shown in the Coverage Schedule of this [Policy]. The Deductible cannot be met with Non-Covered [Charges] [Services or Supplies]. Only Covered [Charges] [Services or Supplies] You [incur] [receive] for wellness services and supplies while insured can be used to meet the Deductible for those charges.

Once the Deductible is met, We [pay benefits] [provide coverage] for other wellness benefits above the Deductible amount incurred by You, subject to the Coinsurance requirement and maximum benefit. But all charges must be incurred while You are insured by this [Policy].

Copayment: You must pay the applicable Copayment for each of the services shown in the Coverage Schedule. After the payment of the Copayment, We will pay the Reasonable and Customary Charges for services and supplies, subject to the applicable Coinsurance, coverage limits and maximum benefits as shown in the Coverage Schedule. **[**You may be required to pay an amount in excess of the Copayment if the charge the Provider bills exceeds the Reasonable and Customary Charge, or if Coinsurance applies to the service.] *[Note to carriers: Include this text if there is a possibility of balance billing.]*

Coinsurance: Coinsurance is the percentage of a Covered Charge that a Covered Person must pay for services and supplies as shown in the Coverage Schedule.

COVERED [CHARGES] [SERVICES OR SUPPLIES]

We will [pay benefits] [provide coverage] for Medically Necessary and Appropriate treatment of an Injury or Illness and for Wellness benefits subject to the terms and conditions of this [Policy].

[Any of the following services which are coverage on an outpatient basis are covered only at the Primary Care Physician's office selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] or [Care Manager]. Services of a Specialist Practitioner which are covered under this [Policy] are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office or at a [Network] [Participating] Hospital outpatient department during office or business hours upon prior written referral by Your Primary Care Physician [or Care Manager]. The Inpatient services are covered when hospitalized by a [Network] [Participating] Practitioner upon prior written referral from Your Primary Care Physician [Care Manager], only at [Network] [Participating] Hospitals and [Network] [Participating] Practitioners (or at [Non-Network] [Non-Participating] Facilities subject to Our preapproval.] *[Note to carriers: Include if issued as a managed care plan.]*

[OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS [POLICY].] *[Note to carriers: Include only if the Utilization Review text is included.]*

This section lists the types of [charges] [services or supplies] We cover. But what We pay is subject to all the terms of this [Policy]. Read the entire [Policy] to find out what We limit or exclude.

Alcoholism and Substance Abuse: We [pay benefits] [provide coverage] for Inpatient and Outpatient treatment of Alcoholism and Substance Abuse. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement and the Alcohol and Substance Abuse Coinsurance as shown on the Coverage Schedule. [Benefits] for Outpatient care [are] [is] subject to the payment of the Alcohol and Substance Abuse Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Alcohol and Substance Abuse are separate from the Coverage Limits for Hospital Confinement.

Treatment may be furnished by a Hospital or Substance Abuse Center.

Anesthetics and the administration of anesthesia: We cover anesthetics and their administration.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes:

a) nursery charges;

b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Biologically–based Mental Illness: We [pay benefits] [provide coverage] for the treatment of a Biologically-based Mental Illness, if such treatment is prescribed by a Practitioner. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Inpatient care for Biologically Based Mental Illness as shown on the Coverage Schedule. Benefits for Outpatient care are subject to the payment of Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Biologically Based Mental Illness are separate from the Coverage Limits for Hospital Confinement.

Blood and blood plasma: We cover blood, blood products and blood transfusions.

Complications of Pregnancy: We cover treatment for the complications of pregnancy.

Diagnostic Tests: We cover Inpatient and Outpatient diagnostic testing. Benefits for Outpatient Diagnostic Tests are limited, as shown in the Coverage Schedule.

Dialysis: We cover charges for Inpatient and Outpatient dialysis.

Emergency Room Services: Coverage for Emergency 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 Practitioner, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. Benefits for Emergency Room Services are subject to the payment of the Copayment as shown on the Coverage Schedule. 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 in the identification card.] *[Note to carriers: Include this text for managed care plans.]*

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Practitioner's fees connected with Hospital care, general acute care, delivery of a child, Surgery, laboratory fees, prescription drugs, dressings and splints.

[Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement as shown on the Coverage Schedule. *Note*: The Coverage Limits for Hospital Confinement are separate from the Coverage Limits for Alcohol and Substance Abuse and Biologically Based Mental Illness.

If You [incur charges] [receive services or supplies] as an Inpatient in a Special Care Unit, We cover the [charges] [services or supplies] the same way We cover other Hospital [charges] [services or supplies].

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered [Charges] [Services or Supplies].

We cover charges for treatment rooms, operating rooms and delivery rooms.

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

These charges are not subject to the Wellness benefit Deductible.

Intravenous Solutions: We cover intravenous solutions administered while an Inpatient or in an Outpatient setting.

Oxygen: We cover charges for oxygen and the administration of oxygen.

Practitioner Charges for Outpatient and Ambulatory Surgery: We cover Practitioner charges for Outpatient and ambulatory Surgery. [Benefits] [Coverage] for Outpatient and ambulatory Surgery [are] [is] subject to the payment of the Copayment as shown on the Coverage Schedule. We do not cover 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 also cover dressings and splints.

Practitioner Charges for Visits: We cover Practitioner charges for visits to treat a diagnosed Illness or Injury. Benefits are limited, as shown on the Coverage Schedule. We also cover dressings and splints.

Pregnancy: As stated in the Hospital Charges section, We cover Practitioner's fees for the delivery of a Child and charges for the use of the delivery room.

Pre-Admission Testing: We cover x-rays and laboratory tests in connection with pre-admission testing needed for a planned Hospital admission or Surgery. We cover these tests if:
a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

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

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

We only cover the Therapy Services listed below.
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.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following Illness, Injury or loss of limb; or treatment related to a Biologically-based Mental Illness to develop a physical function.
Hydrotherapy – the medical use of water in the treatment of certain diseases.

We cover Radiation Therapy and Physical Therapy when it is provided on an Inpatient basis and on an Outpatient basis. We only cover Hydrotherapy when it is provided on an Inpatient basis. Benefits for Outpatient Physical Therapy are subject to the payment of the Copayment shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

Wellness Benefit: We cover wellness services and supplies. Wellness services and supplies include but are not limited to: routine physical examinations, diagnostic services, vaccinations, inoculations, x-ray, mammography, pap smear, bone density testing, nicotine dependence treatment, lead screening and screening tests related to wellness services. Benefits are subject to the payment of the Deductible and Coinsurance as shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

X-Rays: We cover x-rays to diagnose an Illness or Injury. X-Rays done on an Outpatient basis are subject to the limit for Outpatient diagnostic tests as shown on the Coverage Schedule. Except as covered under the Wellness benefit section of this [Policy], We do not pay for x-rays done as part of routine physical checkups.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this [Policy] for twelve months. See the "Definitions" section of this [Policy] for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this [Policy], provided he or she applies for coverage within 63 days of termination of the prior coverage.

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

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

Similarly, We will **credit** the time a Covered Person was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this [Policy], measured from the last date the Creditable Coverage was in force on a premium paying basis.

[Note to carriers: The following Utilization Review text should not be included if issued by an HMO]

[UTILIZATION REVIEW

The decisions made by Our representative(s) in this utilization review program are intended only to determine the extent of reimbursement for a service.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

If You or Your Practitioner do not request Our authorization We will reduce any payment we make by 50% provided We determine the hospital admission, procedure, service or supplies were medically necessary and appropriate. If We determine that performance of the procedure or the hospitalization was not Medically Necessary and Appropriate, We will not make any payment.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial determination by Us that We will not authorize a hospital admission or procedure, services or supplies, You request reconsideration of Our decision and We subsequently determine that the hospital admission or procedure, services or supplies were Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this [Policy].

You will be responsible for paying to the Provider the amount of any reduction of benefits (in addition to any other payments You are required to make under this [Policy]) .

The maximum reduction of benefits under this provision for failure to comply with any of the requirements set forth will be 50% unless We determine that the Hospital admission, procedures, services or supplies were not Medically Necessary and Appropriate.

Any reduction of benefits under this provision are subject to Your rights under the Grievance Procedure provision of this [Policy].

STEP 1 - Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient[; or (b) undergo any of the surgical procedures or receive other services or supplies listed below,] You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected. **If we do not authorize an Inpatient admission and you proceed with that admission, any payment for Facility charges will be reduced by 50%.** However, no reduction will apply if, following an initial Determination by Us that We will not authorize an In-patient admission, You request reconsideration of Our Determination and We subsequently Determine the In-patient admission to have been Medically Necessary and Appropriate, We will make payment as otherwise provided in this [Policy].

SURGICAL PROCEDURES REQUIRING PREAPPROVAL

Adenoidectomy	Knee Replacement
Arthroscopy	Lower Back Surgery
Bunionectomy	Mastectomy
Carpal Tunnel Surgery	Meniscectomy
Cesarean Section	Myringotomy
Cholecystectomy	Pacemaker Implantation
Coronary Artery Angioplasty	Prostatectomy
Coronary Artery Bypass Graft	Rhinoplasty
Esophagoscopy	Septectomy with Rhinoplasty
Excision of Intervertebral Disk	Tonsillectomy
Gastroduodenoscopy	Tubal Transection and/or Ligation
Hip Replacement	Tympanoplasty
Hysterectomy	Tympanotomy Tube

STEP 2 - Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our payment will not be affected. **If we are not notified within the time specified, we will reduce any payment by 50%.**

(a) For **Non- Emergency** Hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must **contact Us at least 3 days prior to admission, treatment or purchase** to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days.

(b) For Emergency Hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us **within 48 hours or on the next business day (whichever is later),** or as soon as reasonably possible, from the commencement of Hospitalization, treatment, or use of supplies,

whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us **at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,** for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, or the next business day, whichever is later, as well as put in writing to You, what specific information is needed to make that Determination. In the event We do not respond to You or Your Practitioner within these time frames, We will not apply the 50% reduction of benefits as allowed by this Utilization Review section to Covered Charges incurred between the time You or Your Practitioner notify Us and We respond to You.

In the event We do not authorize the Hospitalization, procedure, services or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this [Policy].

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

No reduction in benefits or payment will be applied pursuant to this section if, following an initial Determination by Us that We will not authorize a Hospital admission or procedure, services or supplies, You request reconsideration of Our Determination and We subsequently Determine that the Hospital admission or procedure, services or supplies are Medically Necessary and Appropriate. In such an event, We will make payment as otherwise provided in this [Policy].

EXCLUSIONS

The following are <u>not</u> Covered [Charges] [Services or Supplies] under this [Policy]. We will <u>not</u> pay for any charges incurred for, or in connection with:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance

Any charge to the extent it exceeds the Reasonable and Customary Charge

[Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.] *[Note to carriers: Include if issued as a plan that requires referrals.]*

Birthing center charges

Blood or blood plasma which is replaced by You

Broken appointments

Casts, braces, trusses, prosthetic devices, orthopedic footwear and crutches

Chemotherapy

Christian Science

Completion of claim forms

Conditions related to behavior problems or learning disabilities

Cosmetic Surgery, except as stated in this [Policy]; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes

Custodial Care or domiciliary care

Dental care or treatment, including appliances and dental implants

Drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood

Durable medical equipment

Education or training while You are confined in an institution that is primarily an institution for learning or training

Experimental or Investigational treatments, procedures, Hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this [Policy]

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this [Policy]; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy or lasik surgery

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility

Food and food products

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them

Hemodialysis

Herbal medicine

Home health care

Hospice care

Hypnotism

Except as stated below, Illness or Injury 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.

Infusion therapy

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis

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

Marriage, career or financial counseling, sex therapy or family therapy

Nicotine Dependence Treatment, except as provided for under the wellness benefit

Non - Prescription Drugs or supplies

Nutritional counseling and related services

Outpatient Hospital services, except as specifically covered under this [Policy]

Outpatient laboratory tests, except as provided under the Wellness Benefit or the Pre-Admission Testing benefit.

Pregnancy, including charges for pre and post natal care, except Practitioner charges for delivery and charges for the delivery room are covered. Complications of pregnancy are also covered.

Prescription drugs obtained while not confined in a Hospital

Private duty nursing

Rehabilitation center charges

Rest or convalescent cures

Room and board charges for any period of time during which You were not physically present in the room

Routine examinations or wellness care, including related x-rays and laboratory tests, except as otherwise stated in this [Policy]; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Routine Foot Care

Second opinion charges

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not You assert Your 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 You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;

e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) in an amount greater than a Reasonable and Customary charge;
h) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
i) provided by or in a government Hospital unless the services are for treatment: (a) of a non-service Emergency; or (b) by a Veterans' Administration Hospital of a non-service related Illness or Injury; or (c) the Hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
j) provided by or in any locale outside the United States other than in the case of an Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
k) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
l) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto;
m) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this [Policy];
n) which are specifically limited or excluded elsewhere in this [Policy];
o) which are not Medically Necessary and Appropriate, except as otherwise stated in the [Policy].
p) which You are not legally obligated to pay.

Skilled Nursing Facility charges

Skilled nursing care charges

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand-by services required by a Provider

Sterilization reversal

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders

Telephone consultations, except as We may request

Temporomandibular Joint Disorder (TMJ) Treatment

Therapeutic Manipulation

Therapy services, except as specifically covered under this [Policy]

Transplants

Transportation; travel

Treatment of Hemophilia

Treatment of a Non-Biologically-based Mental Illness

Treatment of Wilms tumor

Vision therapy, vision or acuity training, orthoptics and pleoptics

Vitamins and dietary supplements

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness

[Note to carriers: Include the Claims Procedures text in plans that require claims submissions.]

[CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this [Policy] is governed as follows:

You or Your Provider must send Us written notice of a claim. This notice should include Your name and [Policy] number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice and Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following:

a) Your beneficiary;
b) Your estate;
c) Your spouse;
d) Your Parents;
e) Your Children;
f) Your brothers and sisters; and
g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary, - *optional for health service corporations*] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

a) name(s) and address(es) of patient and [Policy]holder;

b) [Policy]holder's [identification] number;
c) date of service;
d) claim number;
e) Provider's name; and
f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the [Policy] provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

[Include the Claims Procedures provision in plans that require the submission of claims.]

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. or N.J.A.C. 8:38A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.]

GRIEVANCE PROCEDURE

[Carriers must include the disclosure requirements set forth in N.J.A.C. 8:38A-3.2]

[Note to carriers: Include the following member provisions if coverage is issued as an HMO plan.]

MEMBER PROVISIONS

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this [Policy] or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us, or as may otherwise by provided by law, may not be disclosed without the Member's written consent.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this [Policy] is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this [Policy], and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the [Policy]holder, coverage may be terminated for the [Policy]holder as well as any of the [Policy]holder's Dependents who are Members. To be eligible for services or benefits under this [Policy], the holder of the card must be a Member on whose behalf all applicable premium charges under this [Policy] have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this [Policy] shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this [Policy] shall be terminated immediately, subject to the Appeal Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this [Policy], or similar causes, the rendition of medical or hospital benefits or other services provided under this [Policy] is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

LIMITATION ON SERVICES

Except in cases of Emergency, services are available only from [Network] [Participating] Providers. We shall have no liability or obligation whatsoever on account of any service or

benefit sought or received by a Member from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT

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

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

APPEAL PROCEDURE

NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 8:38-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

In addition, Carriers are reminded that 29 CFR Part 2560 addresses claims procedures. It is expected that the text included in this Appeals Procedure section will include information the Carrier deems necessary to comply with the requirements of 29 CFR Part 2560.

MEDICAL NECESSITY

Members will receive designated benefits under the [Policy] only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the [Policy] was Medically Necessary and Appropriate, and We have the option to select the appropriate [Network] [Participating] Facility to render services if hospitalization is necessary. Decisions as to Medical Necessity and Appropriateness are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the [Policy] that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Practitioner referred in writing by the Primary Care Physician [or Care Manager] without notifying the Member that such benefit would not be covered under this [Policy].

REFERRAL FORMS
You can be referred for Specialist Services by Your Primary Care Physician [or Care Manager].

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician [or Care Manager].

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeal Procedure and We will continue to provide all benefits covered by the [Policy] during the pendency of the Appeal Procedure. We reserve the right to expedite the Appeal Procedure. If the Appeal Procedure results in a decision upholding the position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this [Policy] for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeal Procedure, to terminate his or her coverage under this [Policy]. In such event, We will continue to provide all benefits covered by this [Policy] for 30 days or until the date of termination, whichever comes first, and We and the Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT
A Member has the right under New Jersey law to refuse life-sustaining treatment. A Member who refuses life-sustaining treatment remains eligible for all benefits in accordance with this [Policy]. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS
HMO is entitled to receive from any provider of services to a Member such information HMO deems is necessary to administer this [Policy] subject to all applicable confidentiality requirements as defined in this [Policy]. By accepting coverage under this [Policy], [Policy]holder, for the [Policy]holder, and for all Dependents covered hereunder, authorizes each

and every Practitioner who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician.

You select a Primary Care Physician from Our Practitioners Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In an Emergency, You may go directly to the emergency room. If You do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will cover services only if We Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER.

The Care Manager will manage authorize Your treatment for a [Biologically Based, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

COORDINATION OF BENEFITS

Purpose Of This Provision
A Covered Person may be covered under this [Policy] and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate what We pay with what Medicare pays or what Medicare would pay. We do this so the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

“Medicare” means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a [Policy] or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable Expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this [Policy] or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an Allowable Expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an Allowable Expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this [Policy] if this [Policy] had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this [Policy] and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expenses under such plans.

How This Provision Works
We apply this provision when a Member or Dependent is covered by this [Policy] and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This [Policy] is the secondary plan. The primary plan (Medicare) pays first, without regard to this [Policy]. The secondary plan (this [Policy]) then pays up to the remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We pay less than We would otherwise pay, We will apply only that reduced amount against payment limits of this [Policy].

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When payment that should have been made by this [Policy] has been made by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance [Policy], You have two options under the terms of Your motor vehicle insurance [Policy]. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle [Policy].

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance [Policy] (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance [Policy] or under similar provisions of a motor vehicle [Policy] required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the New Jersey Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this [Policy].

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this [Policy].

In addition, the motor vehicle insurance [Policy] may provide for secondary benefits in accordance with regulations issued by the New Jersey Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance [Policy] and this [Policy], this [Policy] will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

GENERAL PROVISIONS

THE [POLICY]
The entire [Policy] consists of:
a) the [Policy]holder's application, a copy of which is attached to the [Policy]; and
b) any riders, endorsements or amendments to the [Policy].

STATEMENTS
No statement will void the insurance, or be used in defense of a claim under this [Policy], unless it is contained in a written statement signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

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 You, shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT
The [Policy] may be amended, at any time, without Your consent or the consent of anyone else with a beneficial interest in it. The [Policy]holder may change the type of coverage under this [Policy] at any time by notifying Us in writing.

We may make amendments to the [Policy] upon 30 days' written notice to the [Policy]holder, 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 Individual Health Coverage Program Board.

Only an officer of [Carrier] has 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 signed by an officer of [Carrier].
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 an officer of [Carrier].
c) if a change is required by [Carrier], it is accepted by the [Policy]holder, 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 [Policy]holder, it is shown in an amendment to it signed by the [Policy]holder and by an officer of [Carrier].

CLERICAL ERROR - MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to coverage under this [Policy] will reduce Your coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this [Policy].

TERMINATION OF THE [POLICY] - RENEWAL PRIVILEGE

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the [Policy] will end when that period ends.

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

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

a) You have failed to pay premiums in accordance with the terms of the [Policy], or We have not received timely premium payments; (Coverage will end as of the end of the grace period.)
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) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan (Coverage will end immediately.)
d) 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.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the new individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new Plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may have become eligible for coverage.

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

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

Also, Dependent coverage ends when the [Policy]holder's coverage ends.

Read this [Policy] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

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

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

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this [Policy] is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the [Policy] until 60 days after You file 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.

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

RECORDS - INFORMATION TO BE FURNISHED
We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

CONVERSION PRIVILEGE

If Your spouse loses coverage due to a divorce, he or she may apply for his or her own individual Health Benefits Plan. An application must be made within 31 days of the occurrence of the divorce.

If Your spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the spouse's coverage under this [Policy] ended. Any Pre-existing Condition limitation or other limitation not satisfied by the spouse under this [Policy] will apply under the new coverage to the extent it remains unsatisfied.

CONFORMITY WITH LAW

Any provision of this [Policy] which is in conflict with the laws of the state in which the [Policy] is issued, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

GOVERNING LAW

This entire [Policy] is governed by the laws of the State of New Jersey.