[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[Plan Name]

[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE;	01-01-14
CALENDAR YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$1,000
PER COVERED FAMILY:	$2,000
COlNSURANCE:	20%
MAXIMUM OUT OF POCKET	
PER COVERED PERSON:	$3,000
PER COVERED FAMILY:	$6,000]

[Secretary President]

[Dividends are apportioned each year.]

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

CERTIFICATE INDEX

SCHEDULE OF INSURANCE [PLAN B]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

Coinsurance

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

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

For Preventive Care:	0%

[Vision Benefits (for Covered Persons through the age of 18)

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

[Dental Benefits (for Covered Persons through the age of 18)

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

Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered person maximum.]

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

SCHEDULE OF INSURANCE [PLAN C]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family Deductible.]	[Dollar amount which is two times the individual

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

Coinsurance

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

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

For Preventive Care:		0%
[Vision Benefits (for Covered Persons through the age of 18)		
V2500 – V2599 Contact Lenses	[50%]	
Optional lenses and treatments	[50%]]	
[Dental Benefits (for Covered Persons through the age of 18)		
Preventive, Diagnostic and Restorative services	0%	
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]	
Orthodontic Treatment	[50%]]	
For all other Covered Charges		30%

Maximum Out of Pocket

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

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

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

Per Covered Person per Calendar Year	[An amount equal to [$2,000 - $10,000] plus the Deductible]
[Per Covered Family per Calendar Year	[Dollar amount not to exceed [$6,350]]

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

SCHEDULE OF INSURANCE [PLAN D]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

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

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

For Preventive Care:		0%
[Vision Benefits (for Covered Persons through the age of 18)		
V2500 – V2599 Contact Lenses	[50%]	
Optional lenses and treatments	[50%]]	
[Dental Benefits (for Covered Persons through the age of 18)		
Preventive, Diagnostic and Restorative services	0%	
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]	
Orthodontic Treatment	[50%]]	
For all other Covered Charges		20%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]

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

SCHEDULE OF INSURANCE [PLAN E]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
For all other Covered Charges	
Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family Deductible.]	[Dollar amount which is two times the individual

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

Coinsurance

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

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

For Preventive Care:	0%
[Vision Benefits (for Covered Persons through the age of 18)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the age of 18)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
For all other Covered Charges	10%

Maximum Out of Pocket

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

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum]

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

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

for Preventive Care	NONE
second surgical opinion	NONE
Pre-natal visits	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

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

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

Per Covered Person	[Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

[**Urgent Care Services Copayment** an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and [Carrier] will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The

Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
[For Prescription Drugs	[30%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	30%

Network Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

Non-Network Maximum Out of Pocket

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

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

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

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment
For Preventive Care **NONE**
Pre-natal visits NONE
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [an amount consistent with N.J.A.C. 11:22-5.5(a)]

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Second Surgical Opinion and Prescription Drugs
Per Covered Person [not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family [Dollar amount which is two times the individual Deductible.]]

For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs
for Preventive Care NONE
for immunizations and
lead screening for children NONE
for all other Covered Charges

Per Covered Person [Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family [Dollar amount equal to two times the Non-Network Deductible]]

Emergency Room Copayment (waived if admitted
within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

[**Urgent Care Services Copayment** an amount consistent with N.J.A.C. 11:22-5.5(a)11]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies,

and [Carrier] will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

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

For Preventive Care:	0%
Pre-natal visits	0%
[For Prescription Drugs	[30%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	30%

Network Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

Non-Network Maximum Out of Pocket

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

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

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

times the per Covered Person Maximum.]]

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment
For Preventive Care **NONE**
Pre-natal visits NONE
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [an amount consistent with N.J.A.C. 11:22-5.5(a)]
Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits
Per Covered Person [not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family [Dollar amount which is two times the individual Deductible.]]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

[**Urgent Care Services Copayment** an amount consistent with N.J.A.C. 11:22-5.5(a)11]

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

The **Coinsurance** for the Policy is as follows:
For Preventive Care: 0%
For Prescription Drugs [30%]
For all other services and supplies:
• if treatment, services or supplies are given by a Network Provider 10%
• if treatment, services or supplies are given by a Non-Network Provider 30%

Network Maximum Out of Pocket

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

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

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

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment
For Preventive Care **NONE**
second surgical opinion NONE
Pre-natal visits NONE
For all other treatment, services and supplies given by a **Network** Provider
Physician Visits [an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement [an amount not to exceed $500 up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]

Exception: If the Hospital is a Network facility, the Hospital will be paid as a Network Facility regardless of whether the admitting Practitioner is a Network Practitioner.

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Hospital Confinement and Prescription Drugs
Per Covered Person [not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family [Dollar amount which is two times the individual Deductible.]]

Calendar Year Cash Deductible
For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs
for Preventive Care NONE
for immunizations and
lead screening for children NONE
for all other Covered Charges

Per Covered Person [Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family [Dollar amount equal to two times the Non-Network Deductible]]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

[**Urgent Care Services Copayment** an amount consistent with N.J.A.C. 11:22-5.5(a)11]

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

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

For Preventive Care:	0%
[For Prescription Drugs	30%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	20%

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

Per Covered Person per Calendar Year	[An amount not to exceed [$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

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

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

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

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

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE EPO
(using Plan D, with Copayment on specified services)
[Note to carriers: This Example EPO schedule page illustrates some services and supplies that are not listed on other sample schedule pages. The services and supplies specifically listed on the Example EPO page may be included on other schedule pages. The same is true for text illustrated on other example pages.]

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

Copayment	
For Preventive Care	**NONE**
second surgical opinion	NONE
Pre-natal visits	NONE

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

Primary Care Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
All other Physician Visits	[an amount consistent with N.J.A.C. 11:22-5.5(a)]
Hospital Confinement	[an amount not to exceed $500 up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year][Hospital Outpatient Surgery [an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Ambulatory Surgical Center Copayment	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Facility Outpatient (non-surgical)	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]
[Therapeutic Manipulation	[an amount consistent with N.J.A.C. 11:22-5.5(a)]]

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Hospital Confinement and Prescription Drugs

Per Covered Person	[not to exceed deductible permitted by 45 CFR 156.130(b)]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

Emergency Room Copayment (waived if admitted within 24 hours) [amount consistent with N.J.A.C. 11:22-5.5]

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

[**Urgent Care Services Copayment** an amount consistent with N.J.A.C. 11:22-5.5(a)11]

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

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

For Preventive Care:	0%
For Prescription Drugs:	[20% - 50%]
For Durable Medical Equipment	[20% - 50%]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10% - 50%**]]**

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

Per Covered Person per Calendar Year	[An amount not to exceed[$6,350]]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]]

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

SCHEDULE OF INSURANCE
Example EPO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges. A Tiered Network design may be included with any of the plans that have network benefits.**)**

EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a [Tier 1 or Tier 2] Network Provider. Some services and supplies are available from network providers for which there is no designation of [Tier 1] and [Tier 2]. For such services and supplies refer to the [Tier 2] column. .

SERVICES	**[Tier 1]**	**[Tier 2]]**
Calendar Year Cash Deductible for treatment services and supplies for**:**		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Pre-natal visits	NONE	NONE
Prescription Drugs		[$250]
[Generic Drugs]		[$50]
[Preferred Drugs]		[$100]
[Non-Preferred Drugs]		[$150]
[All other Covered Charges		
Per Covered Person	$500	$1,500
Per Covered Family	$1,000	$3,000]
(Use above deductible for separate accumulation..)		
[All other Covered Charges		
Per Covered Person	$1,000	$2,000
Per Covered Family	$2,000	$4,000
(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)		
Copayment applies after the Cash Deductible is satisfied		

Preventive Care	NONE	NONE
Primary Care Physician Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Pre-natal visits	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]	N/A See Tier 2	50% [10%] [20%] [50%]
Durable Medical Equipment	N/A See Tier 2	50%

[Maximum Out of Pocket Per Calendar Year (See definition below) Per Covered Person	$2,000	$4,350
Per Covered Family	$4,000	$8,700]
(Use above for separate accumulation.)		
[Maximum Out of Pocket		
Per calendar Year (See definition below) Per Covered Person	$2,000	$6,350
Per Covered Family	$4,000	$12,700]
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		

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

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

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

During a Period of Hospital Confinement

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

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

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

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

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- [Speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- [Services and/or prescription drugs to enhance fertility]
- Nutritional Counseling
- [Certain Prescription Drugs] [including Specialty Pharmaceuticals][and certain injectable drugs]
- [Complex Imaging Services]
- [V2500 – V2599 Contact Lenses]]

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

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

Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) For speech therapy see below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits) See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision Note: These services are habilitative services in that they are provided to help develop rather than restore a function.	30 visits
Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) Note: These services are habilitative services in that they are provided to help develop rather than restore a function.	30 visits

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

[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$750 per Covered Person]*
• for all [other] Covered Persons	$500 per Covered Person*

* The $750 and $500 limits do not apply to services from a Network Practitioner.
Note to carriers: Include the asterisks and asterisked text for plans with network benefits.
If the policy is issued as an EPO and provides network only coverage omit this section from the schedule.

Charges for hearing aids for a Covered Person	one hearing aid per hearing impaired

age 15 or younger	ear per 24-month period
Home Health Care	60visits per Calendar Year

[Non-Network Vision benefits for a Covered Person age 18 or younger are subject to the following limits:

Exam	$30 per Calendar Year
Single Vision lenses	$25 per Calendar Year
Bifocal lenses	$35 per Calendar Year
Trifocal lenses	$45 per Calendar Year
Lenticular lenses	$45 per Calendar Year
Elective Contact lenses	$75 per Calendar Year
Medically Necessary Contact lenses	$225 per Calendar Year
Frames	$30 per Calendar Year]

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

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

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

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force.

CLERICAL ERROR - MISSTATEMENTS

Except as stated below, neither clerical error nor programming or systems error by the Policyholder, nor [Carrier] in keeping any records pertaining to coverage under the Policy, nor delays in making entries thereon, will invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. Upon discovery of such error or delay, an appropriate adjustment of premiums will be made, as permitted by law.

Exception: If an Employee contributed toward the premium payment and coverage continued in force beyond the date it should have been validly terminated as a result of such error or delay, the continued coverage will remain in effect through the end of the period for which the Employee contributed toward the premium payment and no premium adjustment will be made.

Premium adjustments involving return of unearned premium to the Policyholder for such errors or delays will be made only if the Employee did not contribute toward the premium payment. Except as stated in the Premium Refunds section of the **Premium Amounts** provision of the Policy, such return of premium will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age or gender of an Employee is found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made.

RETROACTIVE TERMINATION OF A COVERED PERSON’S COVERAGE

[Carrier] will not retroactively terminate a Covered Person's coverage under the Policy after coverage under the Policy take effect unless the Covered Person performs an act, practice, or omission that constitutes fraud, or unless the Covered Person makes an intentional misrepresentation of material fact. In the event of such fraud or material misrepresentation [Carrier] will provide at least 30 days advance written notice to each Covered Person whose coverage will be retroactively terminated.

If a Policyholder continues to pay the full premium for a Covered Person who is no longer eligible to be covered the Policyholder may request a refund of premium as explained in the Premium Refunds provision of the Policy. If [Carrier] refunds premium to the Policyholder the refund will result in the retroactive termination of the Covered Person's coverage. The retroactive termination date will be the end of the period for which premium remains paid. Coverage will be retroactively terminated for the period for which premium is refunded.

[DIVIDENDS
[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Policyholder's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET
[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS
[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

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

LIMITATION OF ACTIONS

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

WORKERS' COMPENSATION

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

CLAIMS PROVISIONS

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

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

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

PROOF OF LOSS
Proof of loss must be sent to [Carrier] within 90 days of the loss.

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

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

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

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

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

DEFINITIONS

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

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

[Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Policyholder's place of business, or at any other place that the Policyholder's business requires the Employee to go.]

Affiliated Company means a company as defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the [Covered Person] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and

d) have written back-up arrangements with a local Hospital for emergency care.

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

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

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

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

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and

c) have written back-up arrangements with a local Hospital for emergency care.

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

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Benefits Program.

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

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

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

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

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

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

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

Covered Charges are Allowed Charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [Certificate] to find out what [Carrier] limits or excludes.

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

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

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

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

[Dependent means Your:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in the Federal Defense of Marriage Act, 1 U.S.C.A. 7, with respect to:

- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. (Neither domestic partners nor civil union partners have COBRA rights. .) and
- the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

Dependent child who is under age 26
Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

Your " Dependent child" includes:

a) Your legally adopted children,
b) Your step-child, [and]
c) the child of his or her civil union partner, [and]
d) [the child of his or her domestic partner and] *[Note to carriers: if domestic partner coverage is not included the following item becomes item d.]*
e) children under a court appointed guardianship.
[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.]

[Dependent's Eligibility Date means the later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

Developmental Disability or **Developmentally Disabled** means a severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the [Covered Person]:
    1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
    2. attains age 26 for all other provisions;
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the [Covered Person's] need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

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

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

Discretion / Determination / Determine means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

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

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors as well as hearing aids which are covered through age 15.

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

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

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

[Employee means a Full-Time bona fide Employee (25 hours per week) of the Policyholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to non-SHOP policies]

[Employee means an Employee of the Policyholder. Seasonal employees (employees working fewer than 120 days in a tax year) are not considered to be employees for

purposes of this Policy. Partners, proprietors and independent contractors are **not** employees of the Policyholder.]
[Note to carriers: the above definition applies to SHOP policies]

Employee Open Enrollment Period means the 30-day period each year designated by the Policyholder during which:

a) Employees and Dependents who are eligible under the Policy but who are Late Enrollees may enroll for coverage under the Policy; and

b) Employees and Dependents who are covered under Policy may elect coverage under a different policy, if any, offered by the Policyholder.

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

Employer means [ABC Company].

Employer Open Enrollment Period means the period from November 15 through December 15 each year beginning in 2014.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period. If an Employee changes plans or if the Employer transfers coverage to another carrier, the Covered Person's Enrollment Date does not change.

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

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

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

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

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

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

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

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

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

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

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

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

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

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will

recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

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

Full-Time means a normal work week of [25] [30] or more hours. Work must be at the Policyholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.
[Note to carriers: Use 25 for non-SHOP and 30 for SHOP policies.]

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

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

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity

coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

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

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

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited as a Hospital by the Joint Commission; or
b) approved as a Hospital by Medicare.

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

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

[Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

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

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

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

Late Enrollee means an eligible Employee [or Dependent] who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage [**and **Dependent Coverage]** section[s] of the Policy.

[Legend Drug means any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

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

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

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

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

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

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

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

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

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

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

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

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered mental illness.

[[Network] Provider means a Provider which has an agreement [directly or indirectly] with [Carrier] to provide covered services or supplies. The Employee will have access to up-to-date lists of [Network] Providers.]

[Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

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

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

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

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

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

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

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

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

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

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

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in the Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in the Policy to "Policyholder" should be changed to read "Planholder"]

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. §1002(16)(B)). That is:

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased the Policy.

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

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

Pre-Approval or Pre-Approved means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.] [For more information regarding the services for which [Carrier] requires Pre-Approval, consult the website at [www.xxx.com]]

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

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

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

Preventive Care. As used in the Policy preventive care means:

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

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

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

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

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

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

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

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

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

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

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

Skilled Nursing Facility (see Extended Care Center.)

[Small Employer means:

a) in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the

employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.; OR

b) in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

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

Special Enrollment Period means a period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
a) Late Enrollees are permitted to enroll under the Policyholder's Policy; and
b) Covered Employees and Dependents who already have coverage are permitted to replace current coverage with coverage under a different policy, if any, offered by the Policyholder.

[Specialty Pharmaceuticals are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education

prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

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

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

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means**:**

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

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

Triggering Event means the following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.

d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.
f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.

Total Disability or Totally Disabled means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

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

[Waiting Period means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.]

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

[You, Your and Yours means an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are [Actively at Work] Full-Time Employees.
[In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

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

Conditions of Eligibility

Full-Time Requirement

[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below,][Carrier] will not insure an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late enrollees may request enrollment during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder’s Policy Anniversary date following enrollment.

Special Enrollment Rules

When an Employee initially waives coverage under the Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under the Policy and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], and will assign an effective date consistent with the provisions that follow provided the coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.
But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under the Policy because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the Policy for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the Policy within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the marriage, birth, adoption, placement for adoption, or placement in foster care. For all other Triggering Events, coverage will take effect as of the first of the month following receipt of the enrollment form.
[Note to carriers: The above Triggering Event paragraph applies to non-SHOP policies.]

If an Employee [or any Dependent] experiences a Triggering Event the Employee [and Dependents] may elect to enroll during the Special Enrollment Period that follows the Triggering Event. The election period is generally the 30 day period following the

Triggering Event. If the Triggering Event is losing or gaining eligibility for Medicaid or NJ Family Care, the election period is 60 days. If the Triggering Event is marriage, coverage will take effect as of the first day of the following month. If the triggering event is birth, adoption, placement for adoption, or placement in foster care, coverage will take effect as of the date of the, birth, adoption, placement for adoption, or placement in foster care. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. For all other Triggering Events, the effective date will be as assigned by the federal government and will depend on the circumstance and the date the application is received.
[Note to carriers: The above Triggering Event paragraph applies to SHOP policies.]

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

Employees in an eligible class on the Effective Date, who have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the Effective Date.

[Employees in an eligible class on the Effective Date, who have not completed at least [90 days] of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under the Policy from the day after Employees complete [90 days] of continuous Full-Time service.] *[Note to Carriers: Omit for SHOP policies]*

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [90 days] of continuous Full-Time service with the Policyholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy as of the first of the month following [15 or 30 or 45 or 60 days] of continuous Full-Time service with the Policyholder.] *[Note to carriers: Applies to - SHOP policies]*

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

Multiple Employment
If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under the Policy. But, if the Policy uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's

earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and]working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.]

The Employee must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the Effective Date of an Employee's coverage.

If the Employee does this more than [30] days after the Employee's Eligibility Date, [Carrier] will consider the Employee a Late Enrollee. The Employee may request enrollment during the Employee Open Enrollment period. Coverage will take effect on the Policyholder's Anniversary date following enrollment.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Policyholder who purchased the Policy purchased it to replace a plan the Policyholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date the Policy takes effect will initially be eligible for limited coverage under the Policy if:

a) the Employee was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the Policy takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under the Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Policy will end one year from the date the person's coverage under the Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Policy.]

Exception: If the coverage under the Policy is richer than the coverage under the Policyholder's old plan, the Policy will provide coverage for services and supplies related to the disabling condition. The Policy will coordinate with the Policyholder's old plan, with the Policy providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends
An Employee's insurance under the Policy will end on the first of the following dates:

a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under the Policy.
c) the date the Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d) the last day of the period for which required payments are made for the Employee, subject to the **Payment of Premiums - Grace Period** section.

[**DEPENDENT COVERAGE**

Policyholder Election
A Policyholder that elects to make Dependent coverage available under the Policy may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Policyholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Policy is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are Your:
a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law, with respect to:

- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended)
- the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent children who are under age 26
Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

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

Your " Dependent child" includes:
a) your legally adopted children,
b) your step-children,
c) his or her foster child, [and]
d) the child of his or her civil union partner, [and]
e) [the child of his or her domestic partner and]
f) children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

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

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

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

The child's coverage ends when Your coverage ends.

Enrollment Requirement
You must enroll Your eligible Dependents in order for them to be covered under the Policy.[Carrier] considers an eligible Dependent to be a Late Enrollee, if You:
a) enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under the Policy, the Plan Sponsor [or [Carrier]] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under the Policy and stated at that time that, such waiver was because they were covered under another group plan and the Employee now elects to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union [or termination of the domestic partnership];
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under the Policy, to be a Late Enrollee, if:

a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

In addition, if an Employee initially waived coverage under the Policy for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under the Policy within 30 days of the date the COBRA continuation ended, [Carrier] will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. . An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Policyholder's Policy Anniversary date following enrollment.

Once an Employee has dependent coverage for Initial Dependents the Employee must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Newly Acquired Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Policyholder who purchased the Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date the Policy takes effect will initially be eligible for limited coverage under the Policy if:

a) the Dependent was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) the Policy takes effect immediately upon termination of the prior plan.

The coverage under the Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Policy will end one year from the date the person's coverage under the Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter coverage will not be limited as described in this provision, but will be subject to the terms and conditions of the Policy.

Newborn Children
[Carrier] will cover an Employee's newborn child for 31 days from the date of birth without additional premium. Health benefits may be continued beyond such 31-day period as stated below:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid. The Employee

must notify [Carrier] of the birth of the newborn child as soon as possible in order that [Carrier] may properly provide benefits under the Policy.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

- give written notice to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, the child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's insurance under the Policy will end on the first of the following dates:
a) [the date] Employee coverage ends;
b) the date the Employee stops being a member of a class of Employees eligible for such coverage;
c) the date the Policy ends;
d) the date Dependent coverage is terminated from the Policy for all Employees or for an Employee's class.
e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f) at 12:01 a. m. [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

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

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

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

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

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

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

What [Carrier] pays is subject to all the terms of the Policy. The Employee should read his or her [Certificate] carefully and keep it available when consulting a Practitioner.

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

If an Employee has any questions after reading his or her [Certificate], he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

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

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

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

POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.

b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies. [Network benefits are shown as [Tier 1] and [Tier 2].]

d)

e) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

f) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge.

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

The Primary Care Practitioner (PCP)

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

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if

the PCP refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and [Carrier] is fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers even though they are not authorized by the PCP, the Covered Person will be eligible for Non-Network Benefits where the [XYZ] provider's charges and the Covered Person's liability are limited to the negotiated fee for the service or supply.

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

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

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

Non-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. Except as stated below, for services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Non-Network Benefits. Exception: If a [Covered Person] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Emergency Services
If a Covered Person requires services for Urgent care or an Emergency which occurs inside the PO Service Area, he or she must notify his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

In the case of Urgent Care or an Emergency, a Covered Person may go to a [XYZ Health Care Network] provider or a non-[XYZ Health Care Network] provider. If a Covered

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

Utilization Review
The Policy has utilization features. See the **Utilization Review Features** section of the Policy.

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What [Carrier] pays is subject to all the terms of the Policy.

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

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

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

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

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS

Definitions

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

Provider Organization (PO)

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

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

The Primary Care Provider (PCP)

Under this Policy a Covered person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO for example, by providing referrals to specialists. Even if a PCP is selected, a Covered person can choose any specialist he or she wants to use. [Whether or not a PCP is selected and office visit to a PCP who qualifies as a PCP is subject to the PCP copayment.

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

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider.

[Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

Emergency Services

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

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

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

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

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

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

[CONTINUATION OF CARE

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

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

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

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

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

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

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

[Carrier] shall not continue services in those instance in which the health care professional has been terminated based upon the opinion of [Carrier's] medical director

that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in the Policy. [Carrier] shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with [Carrier].

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

HEALTH BENEFITS INSURANCE

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

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

BENEFIT PROVISION

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

The Cash Deductible

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

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.]

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

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

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before [Carrier] pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Non-Network Provider, while insured by the Policy, can be used to meet this Cash

Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet either Cash Deductible. What [Carrier] pays is based on all the terms of the Policy.]

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

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

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before [Carrier] pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 2] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

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

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

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before [Carrier] pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before [Carrier] pays benefits for [Tier 1] and [Tier 2] Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, [Carrier] pays benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What [Carrier] pays is based on all the terms of this Policy.]
(*Use the above text if the Tier 1 deductible can be satisfied separately and allows a covered person to be in benefit for further Tier 1 covered charges and is also applied toward the satisfaction of the Tier 2 deductible.)*

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

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

[Family Deductible Limit:
For Other than Single Coverage

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

[Note to carriers: Use the above For Single Coverage Only and Other than Single Accumulation, For example, the text would be included if the plan is a high deductible health plan that could be used in conjunction with an HSA]

[Family Deductible Limit
The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.]

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

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

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

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

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

Tier 1 Family Deductible Limit

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

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

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

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

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

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

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

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

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

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network. Omit the Non-Network text if the plan is an EPO.]

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

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

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

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

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

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

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

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

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

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

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier

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

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

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

Benefits From Other Plans
The benefits [Carrier] will pay may be affected by a Covered Person's being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan
The Policyholder who purchased the Policy may have purchased it to replace a plan the Policyholder had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Policyholder's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:
a) the charges were incurred during the Calendar Year in which the Policy starts or during the 90 days preceding the effective date, whichever is the greater period;
b) the Policy would have paid benefits for the charges if the Policy had been in effect:
c) the Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and
d) the Policy takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.

The Covered Person may have satisfied part of the eligibility Waiting Period under the Policyholder's old plan before it ended. If so, the time satisfied will be used to satisfy the Policy's eligibility Waiting Period if:

a) the Employee was employed by the Policyholder on the date the Policyholder's old plan ended: and
b) the Policy takes effect immediately upon termination of the prior plan.

Extended Health Benefits
If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. [And [Carrier] does not pay for charges incurred by other covered family members.]

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's insurance under the Policy ends; or
c) the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she[or his or her Dependent] is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES
This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [Certificate] to find out what [Carrier] limits or excludes.

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

Except as stated below, [Carrier] covers charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

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

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

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

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

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

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

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

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

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

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

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

[[Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies for Extended Care or Rehabilitation which are not Pre-

Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]

Home Health Care Charges

[Subject to [Carrier's] Pre-Approval,][W][w]hen home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

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

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

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

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

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

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

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

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

Benefits for Home health Care are provided for no more than 60 visits per Calendar Year.

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

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

Practitioner's Charges for Surgery
[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

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

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

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

Dialysis Center Charges
[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

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

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

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

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

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

[Carrier] does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

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

Mental Illness or Substance Abuse
[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Mental Illness or Substance Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Canter; or

e) a Substance Abuse Center..

Pregnancy
The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

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

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

[Benefits for a Covered Newborn Child
[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.]

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

Blood
Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, [Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

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

[[Carrier] will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical

laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for the [Carrier's] network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by [Carrier's] network clinical laboratory.

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

Ambulance Charges

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a) a local Hospital if needed care and treatment can be provided by a local Hospital;

b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or

c) transporting a Covered Person to another Inpatient health care Facility.

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

Durable Medical Equipment

[Subject to [Carrier's] Pre-Approval,][Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option,[and with [Carrier's] Pre-Approval,] [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:

a) replacements or repairs; or

b) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

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

Orthotic or Prosthetic Appliances

We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

Treatment of Wilm's Tumor

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

Nutritional Counseling

[Subject to [Carrier] Pre-Approval,][Carrier] covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

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

Food and Food Products for Inherited Metabolic Diseases

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

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

Specialized Infant Formulas

[Carrier] covers specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under the [Policy] for Prescription Drugs. [Carrier] covers specialized non-standard infant formulas provided:

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

[Carrier] may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under the Policy's Preventive Care section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

[[Subject to [Carrier] Pre-Approval, for certain Prescription Drugs]][Carrier] covers drugs to treat an Illness or Injury [and contraceptive drugs] *[Note to carriers: Omit if requested by a religious employer.]* which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

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

c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

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

In no event will [Carrier] pay for:

a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

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

[[Carrier] has identified certain Prescription Drugs [including Specialty Pharmaceuticals] for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. [Carrier] will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.]

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

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

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

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

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

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

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

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

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

The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

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

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

Such charges will not include charges made for more than:

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

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

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

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

[[Carrier] will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist

and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by [Carrier.]]

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

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

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

Supplies to Administer Prescription Drugs
[Carrier] covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

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

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

[Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Policy as stated above. The Covered Person must pay the deductible and/or coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the Covered Person may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Policy. Upon receipt of such a claim [Carrier] will compare the coverage

for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Policy would have provided if the Covered Person had received intravenously administered or injected anti cancer medications [from the Network or Non-Network Practitioner, as applicable] to determine which is more favorable to the Covered Person in terms of copayment, deductible and/or coinsurance. If the Policy provides different copayment, deductible or coinsurance for different places of service, the comparison shall be to the location for which the copayment deductible and coinsurance is more favorable to the Covered Person. If a Covered Person paid a deductible and/or coinsurance under the Prescription Drug provision that exceeds the copayment, deductible and/or coinsurance that would have applied for intravenously administered or injected anti cancer medications the Covered Person will be reimbursed for the difference.]

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

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial
[Carrier] covers practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. [Carrier] will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

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

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

[Carrier] provides coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

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

Dental Care and Treatment

This Dental Care and Treatment provision applies to all Covered Persons.
[Carrier] covers:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

[Dental Benefits

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, [Carrier] covers the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the age of 18 when services are provided by a [Network] provider.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.

- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

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

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

Preventive Services

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

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

<u>Restorative Services</u>

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

Restorative service to include:

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

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

<u>Endodontic Services</u>

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

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment

f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

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

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

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless

dentures become obsolete due to additional extractions or are damaged beyond repair.

- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
    1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
    2. Flexible base denture including any clasps, rests and teeth
    3. Removable unilateral partial dentures or dentures without clasps are not considered
c) Overdenture – complete and partial
d) Denture adjustments –6 months after insertion or repair
e) Denture repairs – includes adjustments for first 6 months following service
f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
h) Precision attachment, by report
i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
    1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
    2. Obturator prosthesis: surgical, definitive and modifications
    3. Mandibular resection prosthesis with and without guide flange
    4. Feeding aid
    5. Surgical stents
    6. Radiation carrier
    7. Fluoride gel carrier
    8. Commissure splint
    9. Surgical splint
    10. Topical medicament carrier

11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.

Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
    1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
    2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
    3. Considerations and requirements noted for single crowns apply
    4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
    5. Abutment teeth must be periodontally sound and have a good long term prognosis
    6. Repair and recementation

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

<u>Oral and Maxillofacial Surgical Services</u>

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

a) Extraction of teeth:
    1. Extraction of coronal remnants – deciduous tooth,
    2. Extraction, erupted tooth or exposed root
    3. Surgical removal of erupted tooth or residual root
    4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
    1. Oroantral fistula
    2. Primary closure of sinus perforation and sinus repairs
    3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
    4. Surgical access of an unerupted tooth
    5. Mobilization of erupted or malpositioned tooth to aid eruption

6. Placement of device to aid eruption
7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
8. Surgical repositioning of tooth/teeth
9. Transseptal fiberotomy/supra crestal fiberotomy
10. Surgical placement of anchorage device with or without flap
11. Harvesting bone for use in graft(s)

d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
    1. Incision and drainage of abcess - intraoral and extraoral
    2. Removal of foreign body
    3. Partial ostectomy/sequestrectomy
    4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
    1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
    2. Manipulation under anesthesia
    3. Condylectomy, discectomy, synovectomy
    4. Joint reconstruction
    5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
    1. Repair of traumatic wounds – small and complicated
    2. Skin and bone graft and synthetic graft
    3. Collection and application of autologous blood concentrate
    4. Osteoplasty and osteotomy
    5. LeFort I, II, III with or without bone graft
    6. Graft of the mandible or maxilla – autogenous or nonautogenous
    7. Sinus augmentations
    8. Repair of maxillofacial soft and hard tissue defects
    9. Frenectomy and frenoplasty

10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

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

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

a) Limited treatment for the primary, transitional and adult dentition
b) Interceptive treatment for the primary and transitional dentition
c) Minor treatment to control harmful habits
d) Continuation of transfer cases or cases started outside of the program

e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
g) Repairs to orthodontic appliances
h) Replacement of lost or broken retainer
i) Rebonding or recementing of brackets and/or bands

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

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

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
    1. Local anesthesia NOT in conjunction with operative or surgical procedures.
    2. Regional block
    3. Trigeminal division block.
    4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
    5. Intravenous conscious sedation/analgesia – 2 hour maximum time
    6. Nitrous oxide/analgesia
    7. Non-intravenous conscious sedation – to include oral medications
c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
    - One unit equals 15 minutes of additional time
    - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
        - Office or Clinic maximum – 2 units
        - Inpatient/Outpatient hospital – 4 units
        - Skilled Nursing/Long Term Care – 2 units
d) Consultation by specialist or non-primary care provider
e) Professional visits
    - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.

- Hospital or ambulatory surgical center call
    - For cases that are treated in a facility.
    - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
    - General anesthesia and outpatient facility charges for dental services are covered
    - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

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

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

k) Odontoplasty
l) Internal bleaching]

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

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

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, with respect to coverage of TMJ [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of the Policy, and the following limitations:

[Carrier] will cover charges for:
a) one baseline mammogram for a female Covered Person, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.

Please note that mammograms are included under the Preventive Care provision. [A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.] [Note to Carriers; Include if policy includes limited non-network benefits.]

Colorectal Cancer Screening Charges

[Carrier] covers charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger [Covered Persons] who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Covered Person's] Practitioner in consultation with the [Covered Person] regarding methods to use, [Carrier] will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

[Carrier] will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Covered Person's] practitioner in consultation with the [Covered Person.]

High risk for colorectal cancer means a [Covered Person] has:
a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or

c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that [since] colorectal cancer screening is included under the Preventive Care provision[.][, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.] [Note to Carriers; Include if policy includes limited non-network benefits.]

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

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

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

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

[[Subject to [Carrier] Pre-Approval,]][Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or

previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a [Covered Person] who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.

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

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a [Covered Person] who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a [Covered Person's] ability to perform the ordinary tasks of daily living..

i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a [Covered Person] who has been diagnosed with a biologically-based mental illness, physical therapy means treatment to develop a [Covered Person's] physical function.

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

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

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

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

Diagnosis and Treatment of Autism and Other Developmental Disabilities
[Carrier] provides coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability [Carrier] provides coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are and subject to the benefit limits set forth below:

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

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Covered Person's primary diagnosis is autism, and the Covered Person is under 21 years of age, in addition to coverage for the therapy services as described above, [Carrier] also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

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

If a Covered Person:

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

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

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

Fertility Services
[Subject to [Carrier] Pre-Approval][Carrier] covers charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in the Policy. [Carrier] covers charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of the Policy.

[[Carrier] will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under the Policy.]

Preventive Care
[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. [But [Carrier] limits what [Carrier] pays each Calendar Year to:
a) $750 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1,
b) $500 per Covered Person for all other Covered Persons.

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $750 and $500 limits to not apply to services from a Network Practitioner.]
[Note to Carriers: Include only for policies that provide non-network benefits if the carrier chooses to apply the limits to non-network benefits.]

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

Hearing Aids
[Carrier] covers charges for medically necessary services incurred in the purchase of a hearing aid for a Covered Person age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing

fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

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

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

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

Vision Benefit
Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, [Carrier] covers the vision benefits described in this provision for Covered Persons through age 18. [Carrier] covers one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

Therapeutic Manipulation
[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Transplant Benefits
[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas

g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:

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

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

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

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

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

IMPORTANT NOTICE

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

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

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

[What [Carrier] pays is subject to all of the terms of the Policy. Read the [Certificate] carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading the [Certificate] he or she should [call The Group Claim Office at the number shown on his or her identification card.]

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

[UTILIZATION REVIEW FEATURES

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

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

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

Definitions

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

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

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

Grievance Procedure
[Carriers must include the disclosure requirements set forth in N.J.A.C. 11:24A-3.2

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required
[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

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

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

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

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

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.
When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

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

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

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

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

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

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. [[Carrier] reduces what it pays for covered Hospital charges, **by 50%]** if**:**
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

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

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

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

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

[REQUIRED PRE-SURGICAL REVIEW

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

[Carrier] requires a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

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

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or

b) require a second surgical opinion regarding the need for the Surgery.

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

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

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

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

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

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

Penalties for Non-Compliance
As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

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

[SPECIALTY CASE MANAGEMENT

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

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

Please note: [Carrier] has sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

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

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

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

The Specialty Case Management Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;

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

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

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

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

Exclusion
Specialty Case Management does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

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

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

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

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

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

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

EXCLUSIONS

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

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

The amount of any charge which is greater than an ***Allowed Charge***.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

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

Completion of claim forms.

[Preventive contraceptive services and supplies that are rated "A" or "B" by the United States Preventive Services Task Force shall be excluded from this Policy if the Policyholder is a Religious Employer or and Eligible Organization as defined under 45 C.F.R. 147.131, as amended]

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

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

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

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

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

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

Extraction of teeth, except for bony impacted teeth or as otherwise covered under the Policy.

Services or supplies for or in connection with:

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

Services or supplies provided by one of the following members of the Employee's ***family****:* spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

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

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

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

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony. ***Exception***: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

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

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

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

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

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

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

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

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

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

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

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

Benefits may be based on a contractual fee schedule [The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***

a) Charges to administer a Prescription Drug.

b) Charges for:

- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

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

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

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

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

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

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

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home
  or similar institution
- a provider' office.

i) Charges for:

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

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

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

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

o)[Covered Person] taking part in the commission of a felony.

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

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

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

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

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

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

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

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

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

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

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

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

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

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

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

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

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

Services or supplies*:*
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital except as stated below, or unless the services are for treatment:

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

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both the Policy and under military health coverage and who receive care in facilities of the Uniformed Services.
e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or

[Subject to [Carrier] Pre-Approval,] [E][e]ligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. [Charges in connection with full-time students in a foreign country for

which eligibility as a full-time student has not been Pre-Approved by [Carrier] are Non-Covered Charges.]

Stand-by services required by a Provider.

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

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

Telephone consultations.

Transplants, except as otherwise listed in the Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

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

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

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

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A Covered Person who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under this Policy's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:

a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice

Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child (except for the child of the Employee's domestic partner or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.

A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:

a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:

a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee or other person acting on his or her behalf must give the Employer written proof of Social Security's determination of his or her disability within 60 days measured from the latest of:

a) the date on which the Social Security Administration issues the disability determination;
b) the date the group health benefits would have otherwise ended; or

c) the date the Qualified Continuee receives the notice of COBRA continuation rights.

If**,** during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation , any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a Qualified Continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the “special rule” applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee’s subsequent termination of employment or reduction in work hours will be the longer of the following:

a) 18 months from the date of the Employee's termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to [Carrier] on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or

- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of creditable coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:

a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the [Carrier] written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the [Carrier] within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Union [or Domestic Partnership] Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil union [or termination of a domestic partnership], any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities

Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union [termination of domestic partnership] or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
    - the end of the 18-month period; or
    - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union, [or termination of the domestic partnership] or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;
e) the end of the period for which the last premium payment is made;
f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee ; or
g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS

(Applies to all size groups):

As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:

a) has reached the limiting age under the group plan, but is less than 31 years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage

If a Dependent Child is over the age 26 limiting age for dependent coverage and:

a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or

b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election
An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.

a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To maintain continuous group health benefits, the Over-Age Dependent must make written election to [the Carrier] within 30 days of the date the Over-Age Dependent attains age 26. The effective date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first premium is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The effective date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first premium is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent. If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on January 1 following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to all payments other than the first payment such premium payment is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Policy [and will be evidenced by a separate [Certificate] and ID card being issued to the Over-Age Dependent.]. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:

a) the date the Over-Age Dependent:
    1. attains age 31
    2. marries or enters into a civil union partnership;
    3. acquires a Dependent;
    4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
    5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been

insured by the Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of the Policy.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION [OR DOMESTIC PARTNERSHIP] ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved [or if the domestic partnership terminates], the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.]

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN
HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP
Date Group Health Benefits Insurance Ends
Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of the Policy will not apply to him or her and his or her Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 30 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY
Date Transfer To Such Insurance Takes Effect
Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period
[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

Request made because:

a) an HMO ends its operations
b) the Employee [moves outside] [no longer lives, works or resides in]the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer
If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:
a) [an Actively at Work requirement]
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Right to change premium rates
[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A [Covered Person] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Policy] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows [Carrier] to coordinate what [Carrier] pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the [Covered Person] is covered.

DEFINITIONS

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

Allowable Expense: The charge for any health care service, supply or other item of expense for which the [Covered Person] is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Policy] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

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

When this [Policy] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, [Carrier] will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: An amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a [Covered Person] is covered by this [Policy] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

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

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Covered Person] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Covered Person's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:
a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the [Covered Person] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a [Covered Person] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN
[Carrier] considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits

provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Covered Person] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Covered Person] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Covered Person] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Covered Person] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.

c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

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

Benefits may be based on the Allowed Charge (AC), or some similar term. This means that the provider bills a charge and the [Covered Person] may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an Allowed Charge is called an "AC Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the [Covered Person] may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." Fee Schedule Plans may require that [Members] use network providers. Examples of such plans are Health Maintenance Organization plans (HMO) and Exclusive Provider organization plans (EPO). If the [Covered Person] uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule. Examples of

such plans are Preferred provider organization plans (PPO) and Point of Service plans (POS).

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

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

Primary Plan is an AC Plan and Secondary Plan is an AC Plan

The Secondary Plan shall pay the lesser of:

a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary plan, the Secondary plan and the [Covered Person] shall not exceed the fee schedule of the Primary Plan. In no event shall the [Covered Person] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is an AC Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The [Covered Person] shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the [Covered Person] has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall

the [Covered Person] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is an AC Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is an AC Plan or Fee Schedule Plan

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

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or an AC Plan

If the [Covered Person] receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or an AC Plan and Secondary Plan is Capitation Plan

If the [Covered Person] receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The [Covered Person] shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO or EPO and Secondary Plan is an HMO or EPO

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

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related Injury.

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

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

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

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

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

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

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

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

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Policy will apply if:

a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAlC the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:
a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".
d) ["We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner [or an insured domestic partner] who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary
When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a Covered Person who is:
a) under age 65 except for the Employee’s civil union partner [or domestic partner] or the child of the Employee’s civil union partner [or domestic partner].;; and

b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age;
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease ; or
c) A Covered Person who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner].
d) .

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is

the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Policy.

STATEMENT OF ERISA RIGHTS
The following Statement may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to these ERISA requirements

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights, if COBRA is applicable to your plan.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claims for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

[CLAIMS PROCEDURE

Carriers should include claims procedures consistent with the requirements of ERISA.]