EXHIBIT II

[[INTRODUCTION]

What is a Point of Service Plan?
A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of ***Network Providers*** as well as the services of ***Non-Network Providers***. Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either a ***Network Provider*** (subject to any necessary authorization from his or her Primary Care Provider) or those of a ***Non-Network Provider***.

What is the difference between a Network Provider and a non-Network Provider?
A ***Network Provider*** is a doctor, other practitioner or facility that has an agreement with [Carrier] to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. A ***Non-Network Provider*** is any licensed or certified provider that does not have a specific agreement with [Carrier].

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of a ***Network provider*** rather than the services of a ***Non- Network Provider***.

How does the POS plan describe Network and Non-Network coverage?
The POS plan contains a section which describes Network coverage and sections which describe Non-Network coverage. The POS plan also contains many sections which apply to both the use of the services of ***Network Providers*** or the services of ***Non-Network Providers***.

- **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment [deductible and coinsurance] for use of a ***Network Provider*** as well as the deductible and coinsurance requirement for the use of a ***Non-Network Provider***. The **SCHEDULE** also identifies some limitations to coverage.

- **COVERED SERVICES AND SUPPLIES**. This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of a ***Network Provider***.

- **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if he or she were to use the services of a ***Non-Network Provider***.

How does a person access Network Providers?
[Carrier] will provide a [directory] listing all the Primary Care Providers and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Provider, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying [Carrier].

Except in case of an Emergency or Urgent Care, Network services and supplies can **only** be provided by a ***Network Provider*** (subject to any necessary authorization from his or her Primary Care Provider). [While certain routine OB/GYN care may be secured without going through the PCP, all other Network services and supplies require the authorization of the PCP.]

How much will it cost for services and supplies if a person uses Network Providers?
[The Identification Card will specify the amount of the copayment, the ***Network provider*** will collect for [most] [some] services and supplies.] For [many] [some] services, after a person pays a copayment for the PCP visit, further services and supplies require no additional payment. [Home Health Care and Durable Medical Equipment are examples of such services and supplies.] [The plan may provide for deductible and coinsurance on services other than Primary Care Provider and pre-natal care services.]

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of a Non-Network Provider?
Persons covered under a POS plan may use the services of a Non-Network Provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from [Carrier], as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses Non-Network Providers?
After the payment of the applicable [Calendar] [Plan] Year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit were the first Non-Network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, [Carrier] would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a [Calendar] [Plan] Year, further charges are only subject to the applicable coinsurance. **Note**: [Carrier] pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Allowed Charge, as defined in the Contract and the Evidence of coverage.

Does the POS plan cover the same services and supplies whether a person uses in-Network providers or Non-Network providers?
The POS plan was designed to include the same services and supplies whether the person uses ***Network*** or ***Non-Network Providers***. However, the **extent** of coverage differs for some services and supplies. For example, if a person elects to use a ***Network Provider*** for extended care services (skilled nursing care), coverage is unlimited as to number of days. If a person uses a ***Non-Network provider***, extended care services are limited to 120 days.

Since in-network services and supplies must be coordinated by a PCP, and ***Network*** P***roviders*** are familiar with in-network covered services and supplies, the list of in-Network covered services and supplies in a POS plan does not generally include as much detail as the list of out-of -network covered charges. In addition, [Carrier] is able to offer more details as to the nature and extent of the Network coverage.

For services and supplies that are subject to limitations, can a person receive both Network and Non-Network services and supplies?
The POS plan allows a person to receive any combination of in-network and out-of -network services and supplies. However, for services and supplies subject to limitations, the POS plan includes offset provisions to coordinate the **total** services and supplies a person may receive.

PLEASE REFER TO THE CONTRACT [AND EVIDENCE OF COVERAGE] FOR COMPLETE INFORMATION CONCERNING THE POS PLAN AND USE OF NETWORK AND NON-NETWORK PROVIDERS.]

[Note to Carriers: The Introduction text may be included or omitted, at the option of the carrier.]

[Carrier] **HMO - POS PLAN**
[Plan Name]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)
POINT OF SERVICE (POS) EVIDENCE OF COVERAGE

[Carrier] certifies that the Employee named below is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between [Carrier] and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

CONTRACTHOLDER:	[ABC Company]
GROUP CONTRACT NUMBER	[G-12345]
[**EMPLOYEE**	John Doe]
EVIDENCE OF COVERAGE NUMBER	C-123456]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE:	[January 1, 2018]
SERVICE AREA	[State of New Jersey]
AFFILIATED COMPANIES:	[DEF Company]

[COST OF COVERAGE
The coverage described in this Evidence of Coverage is Contributory Coverage. You will be advised of the amount of Your contribution when You enroll.]

[Carrier's address
100 Main Street, Any Town, NJ 00000-0000]

HMO/POS-EOC

[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 [Members]]

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

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SECTION PAGE

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using copayment for network services)
[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Hospital		
Inpatient (unlimited days)	[$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30 Copayment / visit	Deductible/Coinsurance]
Pre-natal care	[$0] Copayment / visit	Deductible/Coinsurance
Practitioner Services	[$15] Copayment / visit	Deductible/Coinsurance
Preventive Care	[$0] Copayment / visit	[Deductible/Coinsurance]
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
[Complex Imaging Services	[$30 Copayment]	Deductible/Coinsurance]
[All other] Diagnostic Services Inpatient Outpatient Visit	 $0 Copayment [$15] Copayment	 Deductible/Coinsurance Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Home Health Care	Covered; $[30] Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using separate deductible/coinsurance and maximum out of pocket for network and non-network services)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-natal care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
[Urgent Care	[$30] Copayment / visit	Deductible/Coinsurance]
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50] Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment Deductible or Coinsurance	[Deductible/ Coinsurance]
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	[Non-Network] Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network	
Per Member	[not to exceed $2,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]
Non-Network	
Per Member	[Dollar amount not to exceed three times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]
Coinsurance	
Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

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

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

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

[[Outpatient Surgery (facility charges)] Coinsurance Limit: $[500] per [surgery]]
Note to carriers: Outpatient surgery may be replaced with any other service or supply for which coinsurance is required.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] 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

Member 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] [Plan] Year.

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

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

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

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (using common deductible and maximum out of pocket for network and non-network services but separate coinsurance)

[Note to carriers: Dollar amounts shown on the schedule pages are illustrative only. Refer to N.J.A.C. 11:21-3.1 for permissible ranges. Network benefits may be structured with tiers. For an example refer to the HMO contract form, Appendix Exhibit G.]

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Primary Care Provider Visits	[$15] Copayment / visit	Deductible/Coinsurance
Pre-natal care	No Copayment, Deductible or Coinsurance	Deductible/Coinsurance
Emergency Room	[$50] Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	[$50]Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
[Urgent Care	[$30] Copayment/visit	Deductible/Coinsurance]
Immunizations and lead screening for children	No Copayment, Deductible or Coinsurance	Coinsurance
Preventive Care	No Copayment, Deductible or Coinsurance	[Deductible/ Coinsurance]
Orally administered anti-cancer prescription drugs	Refer to the Covered Services and Supplies and Covered Charges sections	Refer to the Covered Services and Supplies and Covered Charges sections
All other Prescription Drugs	Deductible/Coinsurance	Deductible/Coinsurance
All other services and supplies	Deductible/Coinsurance	Deductible/Coinsurance

Cash Deductible per [Calendar] [Plan] Year

Network and Non-Network

Per Member	[amount not to exceed $2,000]
[Per Covered Family	[Dollar amount which is two times the individual Deductible.]]

Coinsurance

Network	[50% - 10%, in 5% increments]
Non-Network	[50% - 10%, in 5% increments]

Network Maximum Out of Pocket

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

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

Per Member per [Calendar] [Plan] Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]

[Per Covered Family per [Calendar] [Plan] Year	[Dollar amount equal to two times the per Member maximum.]]

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

LIMITATIONS ON SERVICES AND SUPPLIES

:Unless otherwise stated, the following limitations represent the maximum number of days or visits for use of any combination of Network and Non-Network Providers.

Charges for Home Health Care	60 Visits
Charges for therapeutic manipulation per [Calendar] [Plan] Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined) 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] [Plan] Year (combined) 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] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision **Note**: The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for physical and occupational per [Calendar] [Plan] Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) **Note**: The 30-visit limit does not apply to the treatment of autism.	30 visits
Charges for hearing aids for Members age 15 or younger	One hearing aid per hearing impaired ear per 24-month period

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	
Network:	Unlimited
Non-Network:	Unlimited

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PROVIDER . READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THE CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

REFER TO THE SECTION OF THE CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES" FOR A LIST OF THE SERVICES AND SUPPLIES AND CHARGES FOR WHICH A [MEMBER] IS NOT ELIGIBLE.

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

During a Period of Hospital Confinement

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

For private room and board accommodations, We will cover charges up to the Hospital's average 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 [Member] is being isolated in a private room because the [Member] has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

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

During a Confinement in an Extended Care Center or Rehabilitation Center
We will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

DEFINITIONS

The words shown below have specific meanings when used in the Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help [Members] understand what services and supplies and benefits are provided.

ACCREDITED SCHOOL. 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. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Contractholder's place of business, or at any other place that the Contractholder's business requires the Employee to go.]

AFFILIATED COMPANY. A company 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 Us using the method specified below ; or
• the negotiated fee schedule.

[Carrier must specify the method used to determine the allowed charge and explain how a covered person may learn the allowed charge for *a service the Member may receive.]*

For charges that are not determined by a negotiated fee schedule, the [Member] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

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

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

It must carry out its stated purpose under all relevant state and local laws and be 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.

A Facility is not an Ambulatory Surgical Center, for the purpose of the Contract, if it is part of a Hospital.

ANNIVERSARY DATE. The date which is one year from the Effective Date of the Contract and each succeeding yearly date thereafter.

[APPROVED CANCER CLINICAL TRIAL. 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. 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.

It must:
a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

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

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

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

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

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a [Member]. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

[COMPLEX IMAGING SERVICES. 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.]

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which [Member] must pay for certain Covered Services or Supplies or Covered Charges. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance*.

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

COVERED CHARGES. Allowed Charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to [Non-Network] benefits. The services and supplies must be:
a) furnished or ordered by a 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 Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by the Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to [Network] benefits.

Read the entire Contract to find out what We limit or exclude.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) 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. Any service or supply, including room and board, which:
a) is furnished mainly to help a [Member] meet a [Member's] routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[DEPENDENT. Your:
a) legal spouse which, for purposes of dependent eligibility but not for purposes of the Employee definition, 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; and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

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

Note: If the Contractholder 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 **Eligibility** section of the Contract.

Your "Dependent child" includes Your legally adopted child, Your step-child, Your foster child, the child of his or her civil union partner, [and] [, the child of his or her domestic partner, and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. 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 [Member] attains age 26;
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 [Member's] need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under the Contract if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a [Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs as well as hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.

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

EFFECTIVE DATE. The date on which coverage begins under the Contract for the Contractholder, or the date coverage begins under the Contract for a [Member], as the context in which the term is used suggests.

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

EMPLOYEE. An Employee of the Contractholder under the common law standard as described in 26 CFR 31.3401(c)-1. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are **not** employees of the Contractholder. Employee also excludes a leased employee.

EMPLOYEE OPEN ENROLLMENT PERIOD. The 30-day period each year designated by the Contractholder during which:
a) Employees and Dependents who are eligible under the Contract but who are Late Enrollees may enroll for coverage under the Contract; and
b) Employees and Dependents who are covered under Contract may elect coverage under a different policy, if any, offered by the Contractholder.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment;
b)[the day] after any applicable waiting period ends; or
c) [the day] after any applicable Orientation Period ends.

EMPLOYER. [ABC Company].

EMPLOYER OPEN ENROLLMENT PERIOD. The period from November 15 through December 15 each year.

ENROLLMENT DATE. With respect to a [Member], 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 [Member's] Enrollment Date does not change.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:
a)not of proven benefit for the particular diagnosis or treatment of a [Member's] particular condition; or
b)not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a [Member's] particular condition; or
c)provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.
We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member's] particular condition.

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

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

1. Any medical device, drug, or biological product must have received final approval to market by the 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:
a) The American Hospital Formulary Service Drug Information; or
b) The United States Pharmacopeia Drug Information

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

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

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

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

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

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Facility.

FACILITY. A place 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. A normal work week of [25] [30] or more hours. [Please note that the definition of Small Employer uses a definition of full-time that is used solely for the definition of Small Employer.] Work must be at the Contractholder'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 include the please note sentence. Use 30 for SHOP policies.]

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

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" 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. 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. 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. 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. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) be accredited for its stated purpose by The Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by The Joint Commission; or
b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or persons with Substance Use Disorder is not a Hospital.

ILLNESS or ILL. A sickness or disease suffered by a [Member] or a description of a [Member] suffering from a sickness or disease. Illness includes Mental Illness and Substance Use Disorder.

[INITIAL DEPENDENT. 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. Damage to a [Member's] body, and all complications arising from that damage, or a description of a [Member] suffering from such damage.

INPATIENT. [Member], if physically confined as a registered bed patient in a Hospital or other health care Facility; or services and supplies provided in such a setting.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under the Contract 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] subsection[s] of the **Eligibility** section of the Contract.

[LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.]

[MAIL ORDER PROGRAM. A program under which a [Member] 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. Only a Prescription Drug used for the treatment of chronic medical conditions.]

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a [Member's] convenience;
e) the most appropriate level of medical care that a [Member] needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

MEDICARE. 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.

[MEMBER]. An eligible person who is covered under the Contract (includes Covered Employee[and covered Dependents, if any)].

[**[MEMBER] SERVICES**. Carrier has the option to include a definition of such services in the Contract.]

MENTAL HEALTH FACILITY. A Facility that mainly provides treatment for people with Mental Illness. It will be considered 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. 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. A Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. The Employee will have access to up to date lists of [Network] Providers.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "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. Charges which do not meet the Contract's definition of Covered Charges or which exceed any of the benefit limits shown in the Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by the Contract.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies and Non-Covered Charges, or which exceed any of the limitations shown in the Contract.

[NON-NETWORK] PROVIDER. A Provider which is not a [Network] Provider.

[**NON-PREFERRED DRUG.** A drug that has not been designated as a Preferred Drug.]

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

[ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).]

ORTHOTIC APPLIANCE. 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. [Member], if **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. 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.** A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

PERIOD OF CONFINEMENT. 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 Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

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. 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.

PRACTITIONER. A medical practitioner who:
a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b) provides medical services which are within the scope of the practitioner's 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. Our approval using paper or electronic means for specified services and supplies prior to the date the charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise by payable under the Contract. For more information regarding the services for which We require Pre-Approval, consult the website at [www xxx.com]]

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

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

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member'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 [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- 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 and Appropriate services associated with the administration of the drugs.
In no event will We pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b)any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. As used in this Contract 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 [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] 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 [Members] 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, prostate cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PROVIDER (PCP). A [Network] Practitioner who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology for pre and post-natal care, birth and treatment of diseases and hygiene,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member's] Referral for Specialist Services; and is responsible for maintaining continuity of patient care. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

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

PROSTHETIC APPLIANCE. 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. A recognized Facility or Practitioner of health care.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Provider in conformance with Our policies and procedures that direct a [Member] to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a)be accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b)be approved for its stated purpose by Medicare.
In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, 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. The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges**.

SERVICE AREA. As applicable to [Network] services and supplies, the geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Nurse, and require the technical skills and professional training of a Nurse.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by The Joint Commission; or
b) be approved for its stated purpose by Medicare.
In some places, a "Skilled Nursing Center" may be called an Extended Care Center.

SMALL EMPLOYER. Means 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.

Please note: Small Employer includes an employer that employs more than 50 full-time Employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

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

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

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

SPECIAL ENROLLMENT PERIOD. 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 Contractholder'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 Contractholder.

[SPECIALTY PHARMACETICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.
Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.]

SUBSTANCE USE DISORDER. The term as defined by the American Psychiatric Association in the Diagnostic and Statistical manual of Mental Disorders, Fifth Edition, and any subsequent editions. Substance Use Disorder includes substance use withdrawal.

SUBSTANCE USE DISORDER FACILITY. A Facility that mainly provides treatment for people with Substance Use Disorder. We will recognize such a Facility if it carries out its stated purpose under all relevant state and local laws, and it is either:
a)accredited for its stated purpose by The Joint Commission; [or]
b)approved for its stated purpose by Medicare[.][;]
c) [accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);or;
d) credentialed by Us.]

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

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

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

THE JOINT COMMISSION. The entity that evaluates and accredits or certifies health care organizations or programs.

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

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in the Contract, 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.

TRIGGERING EVENT. 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 or Carrier.
d) The date an Employee or eligible Dependent demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move provided the Employee and/or Dependent demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
f) The date NJFamilyCare determines an Employee or Dependent who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.

g) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
h) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
i) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
j) The date of a court order that requires coverage for a Dependent.

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

[WAITING PERIOD. 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. The Waiting Period begins on the first day following the end of the Orientation Period, if any.]

[WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. An Employee who is covered under the Contract.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] [and] [who live, work or reside in the Service Area] 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.]

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,]We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

Enrollment Requirement
We will not cover 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 will 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;

We 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 Contractholder's Contract Anniversary date following enrollment.

Special Enrollment Rules
When an Employee initially waives coverage under the Contract, the Plan Sponsor [or We] 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 Contract 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 Contract, We 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 Contract and pay the appropriate premium 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 Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under the Contract within 30 days of the date the COBRA continuation ended, We 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 Contract 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 Contract 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. If the Triggering Event is loss of minimum essential coverage the effective date will be the first day of the following month. If the triggering event is loss of minimum essential coverage the effective date may be as early as the day after the loss of minimum essential coverage. 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 [Orientation Period and]Waiting Period
The Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under the Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under the Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under the Contract. But, if the Contract 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, We 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 Effective Date of an Employee's coverage.
If the Employee does this more than [30] days after the Employee's Eligibility Date, We 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 Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:

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

Except as stated below, the coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract 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 Contractholder'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 Contract.]
Exception: If the coverage under the Contract is richer than the coverage under the Contractholder's old plan, the Contract will provide coverage for services and supplies related to the disabling condition. The Contract will coordinate with the Contractholder's old plan, with the Contract providing secondary coverage, as described in the Coordination of Benefits and Services provision.

When Employee Coverage Ends
An Employee's coverage under the Contract 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 Contract.
c) the date the Contract 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 have been made for the Employee, subject to the **Payment of Premium - Grace Period** section.
e) [the date] an Employee no longer lives, works or resides in the Service Area.]

[DEPENDENT COVERAGE

Contractholder Election
A Contractholder that elects to make Dependent coverage available under the Contract 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 Contractholder limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Contract is limited to Dependent Children.

Eligible Dependents for Dependent Health Benefits
Your eligible Dependents are:
a) Your 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); and
   - The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.
b) Your Dependent children who are under age 26.

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

[Exception: Except for an Employee's Dependent children who are under age 26, any Dependent who does not reside in the Service Area is not an eligible Dependent.]

Adopted Children, Step-Children, Foster Children
Your "unmarried Dependent children" include Your legally adopted children, Your step-children, Your foster children, the child of his or her civil union partner, [and] [, the child of his or her domestic partner and] children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past the Contract'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 Contract's age limit;
b) the child became covered under the Contract or any other policy or Contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
c) the child depends on the Employee for most of his or her support and maintenance.

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

The child's coverage ends when the Employee's coverage ends.

Enrollment Requirement
An Employee must enroll his or her eligible Dependents in order for them to be covered under the Contract. We consider an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her 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 Contract, the Plan Sponsor [or We] 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 Contract 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 Contract, 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, and the appropriate premium must be paid, 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, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under the Contract, 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, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

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

In addition, if an Employee initially waived coverage under the Contract 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 Contract within 30 days of the date the COBRA continuation ended, We 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 an Employee's Dependent coverage to begin, the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of the Contract, the date an Employee's Dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the [first day of the calendar month following the] Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.
[Note to Carriers: Include the bracketed text in item a) for SHOP policies.]

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We 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 Contractholder's Contract Anniversary date following enrollment.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the [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 Us [and agrees to make any additional payments], or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.
[Note to Carriers: Include the bracketed text in item b) for SHOP policies.]

If the Contractholder who purchased the Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date the Contract takes effect will initially be eligible for limited coverage under the Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) the Contract takes effect immediately upon termination of the prior plan.

The coverage under the Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under the Contract will end one year from the date the person's coverage under the Contract 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 Contractholder'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 Contract.

Newborn Children
We will cover an Employee's newborn child for 60 days from the date of birth without additional premium. Coverage may be continued beyond such 60-day period as stated below:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 60 days, provided the premium required for Dependent child coverage continues to be paid. The Employee must notify Us of the birth of the newborn child as soon as possible in order that We may properly provide coverage under the Contract.
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
1) give written notice to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 60 days after the date of birth for coverage to continue beyond the initial 60 days.]

If the notice is not given [and the premium is not paid] within such 60-day period, the newborn child's coverage will end at the end of such 60-day period. If the notice is given and the premium paid after that 60-day period, the child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's coverage under the Contract 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 Contract ends;
[d)]. the date Dependent coverage is dropped from the Contract for all Employees eligible for such coverage;
[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 midnight [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.
[g)]. with respect to a Dependent spouse, the date the spouse moves his or her permanent residence outside the Service Area.]

EXTENDED HEALTH BENEFITS

If the Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under the Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of the Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other 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 coverage under the Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

TERMINATION FOR CAUSE
If any of the following conditions exist, We may give written notice to the [Member] that the person is no longer covered under the Contract:

a) **Untenable Relationship:** After reasonable efforts, We and/or [Network] Providers are unable to establish and maintain a satisfactory relationship with the [Member] or the [Member] fails to abide by our rules and regulations, or the [Member] acts in a manner which is verbally or physically abusive.
b) **Misuse of Identification Card:** The [Member] permits any other person who is not authorized by Us to use any Identification Card We issue to the [Member].

c) **Furnishing Incorrect or Incomplete Information:** The [Member] furnishes material information that is either incorrect or incomplete in a statement made for the purpose of effecting coverage under the Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
d) **Nonpayment:** The [Member] fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Contract.
e) **Misconduct:** The [Member] abuses the system, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
f) **Failure to Cooperate:** The [Member] fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** section.

If We give the [Member] such written notice:
a) that person will cease to be a [Member] for the coverage under the Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
b) no benefits will be provided to the [Member] under the Contract after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeals Procedures We establish.

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Provider and identify himself or herself as a [Member] of this program.

In an Emergency, a [Member] may go directly to the emergency room. If a [Member] does, then the [Member] must call his or her Primary Care Provider and [Member] Services within 48 hours. If a [Member] does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Provider.

[Members] select a Primary Care Provider from Our [Physician or Practitioners Directory]; this choice is solely a [Member's]. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Provider initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Provider selection. [If a [Member] fails to select a Primary Care Provider, We will make a selection on behalf of the [Member].]

[After initially selecting a Primary Care Provider, [Members] can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The [[Member] can select another Primary Care Provider from Our [Physician or Practitioners] Directory].

For a discretionary change of PCP, 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.

[NETWORK
The Member will have access to given up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network 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.]]]

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

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

CONFIDENTIALITY
Information contained in the medical records of [Members] and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of the Contract or in the

compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by [Member] against Us, may not be disclosed without the [Member's] written consent, except as required or authorized by law.

INABILITY TO PROVIDE [NETWORK] SERVICES AND SUPPLIES

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

REFERRAL FORMS

A [Member] can be Referred for Specialist Services by a [Member's] Primary Care Provider.

Except in the case of an Emergency, a [Member] will not be eligible for any [Network] services provided by anyone other than a [Member's] Primary Care Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

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

REFUSAL OF LIFE-SUSTAINING TREATMENT

A [Member] has the right under New Jersey law to refuse life sustaining treatment. A [Member] who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with the Contract. We will follow a [Member's] properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a [Member], such information We deem is necessary to administer the Contract, subject to all applicable confidentiality requirements as defined in the Contract. By accepting coverage under the Contract, Employee, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the [Member] hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of the [Member] and render reports pertaining to same to Us, upon request, and to permit copying of a [Member's] records by Us.

MEDICAL NECESSITY

[Members] will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, We have the option to select the appropriate [Network] Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible [Member] for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Provider or a Provider referred in writing by the Primary Care Provider without notifying the [Member] that such benefit would not be covered under the Contract.

PROVIDER PAYMENT

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

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

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process. The text must address the specific appeals process and in-plan exception required by P.L. 2017, c.28.

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

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

We shall assure continued coverage of covered services at the Contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the [Member] to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

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

In case of pregnancy of a [Member], coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the [Member], up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

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

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

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

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

If a [Member] is admitted to a health care Facility on the date the Contract is terminated, We shall continue to provide benefits for the [Member] until the date the [Member] is discharged from the Facility**.**

We shall not continue services in those instance in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a Determination of fraud or a breach of Contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a [Member's] continued treatment with a health care professional shall be subject to the appeal procedures set forth in the Contract. We shall not be liable for any inappropriate treatment provided to a [Member] by a health care professional who is no longer employed by or under Contract with Us

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

COVERED SERVICES AND SUPPLIES ***APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES***

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [Cash Deductible] [or Coinsurance] as stated in the applicable Schedule and subject to the terms, conditions and limitations of the Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

[COVERAGE 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] [Plan] Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.]

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each [Calendar] [Plan] Year. Once two Members in a family meet their individual Cash Deductibles in a [Calendar] [Plan] Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year. What We pay is based on all the terms of this Contract.]

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

[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] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(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] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]

(*Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)*
[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule.]

[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] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(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] [Plan] Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

Each [Calendar] [Plan] Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1 or a Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year.

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

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a [Calendar] [Plan] 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 Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies for the remainder of the [Calendar] [Plan] Year.]

[Once Members in a family meet two times the individual Maximum Out of Pocket, no Member 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] [Plan] Year.]

[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.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member 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] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member 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] [Plan] 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 Member must pay as Copayment, Deductible and Coinsurance for all Tier 1 Network Covered Services and Supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.
Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member 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] [Plan] Year.

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network Covered Services and Supplies in a [Calendar] [Plan] Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Member 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] [Plan] Year.

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member 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] [Plan] Year.
(*Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)*

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

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

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

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

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

supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

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

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

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

The Cash Deductible:
For Single Coverage Only: [Tier 1]
Each [Calendar] [Plan] Year, a [Member] must have Covered Charges that exceed the [Tier 1] per [Member] Cash Deductible before We pay any benefits to the [Member] for those charges. The [Tier 1] per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by a [Member] while insured can be used to meet the Cash Deductible.

Once the [Tier 1] per [Member] Cash Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by the [Member], less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the [Member] is insured by the Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

For Single Coverage Only: [Tier 2]
Each [Calendar] [Plan] Year, a [Member] must have Covered Charges that exceed the [Tier 2] per [Member] Cash Deductible before We pays any benefits to a [Member] for those charges. [Covered Charges applied to the [Tier 1] per [Member] Cash Deductible also apply to this [Tier 2] per [Member] Cash Deductible.] The [Tier 2] per [Member] Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by a [Member] while insured can be used to meet the Cash Deductible.

Once the [Tier 2] per [Member] Cash Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by the [Member], less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the [Member] is insured by the Contract. And what We pay is based on all the terms of the Contract including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage: [Tier 1]
The [Tier 1] per [Member] Cash Deductible is **not** applicable. The Contract has a [Tier 1] per Covered Family Cash Deductible which applies in all instances where the Contract provides coverage that is not single only coverage. Once any combination of [Members] in a family meets the [Tier 1] per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Charges incurred by any [Member] of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year.

For Other than Single Coverage: [Tier 2]
The [Tier 2] per [Member] Cash Deductible is **not** applicable. The Contract has a [Tier 2] per Covered Family Cash Deductible which applies in all instances where the Contract provides coverage that is not single only coverage. Once any combination of [Members] in a family meets the [Tier 2] per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Charges incurred by any [Member] of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] Year. [Note that Covered Charges applied to the [Tier 1] per Covered Family Cash Deductible also apply to this [Tier 2] per Covered Family Cash Deductible.]

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

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

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

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

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

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

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

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

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

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

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

Note to carriers: The Coverage Provision section is only to be included in plans where Network coverage is subject to deductible and coinsurance.]

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*
(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Provider's office selected by a [Member], or elsewhere upon prior Referral by a [Member's] Primary Care Provider.

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Provider.
3) **Periodic health examinations** to include:
a) Well child care from birth including immunizations;
b) Routine physical examinations, including eye examinations;
c) Routine gynecological exams and related services;
d) Routine ear and hearing examination; and
e) Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).
4) **Diagnostic Services.**
5) Casts and dressings.
6) **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Provider and Pre-Approved by Us.
7) **Procedures and Prescription Drugs to enhance fertility**, except where specifically excluded in the Contract. [Subject to Pre-Approval,] We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. . The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
8) **Orthotic or Prosthetic Appliances** We cover Orthotic Appliances or Prosthetic Appliances if the Member'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 in Our Network. Benefits for the appliances will be provided to the same extent as other Covered Services and Supplies under the Contract.
9) Durable Medical Equipment when ordered by a [Member's] Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10) [Subject to Our Pre-Approval, as applicable, **]Prescription Drugs which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]
[A prescription or refill will not include a prescription or refill that is more than:

a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] [Network] Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.]

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

[We have identified certain Prescription Drugs for which Pre-Approval is required [including Specialty Pharmaceuticals]. We will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. We will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

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

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.
[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member 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 Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] 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 Contract 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, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We 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 Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We 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 Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract 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 Contract.

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 Member's Practitioner.

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

[[We 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 Us.]

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

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member 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 Member prior to dispensing the drug.]

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

11) **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 [Member's] Primary Care Provider and approved in advance by Us.
12) **Dental x-rays** when related to Covered Services.
13) **Oral Surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases**: We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a [Member'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.
15. Specialized non-standard infant formulas are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.
16. [Donated Human Breast Milk
We cover pasteurized donated human breast milk for [Members] under the age of six months subject to the following conditions:
a) The [Member] is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the [Member's] mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
b) The [Member's] Practitioner issued an order for the donated human breast milk

We also cover pasteurized donated human breast milk as ordered by the [Member's] Practitioner for [Members] under the age of six months if the [Member] meets any of the following conditions:
a) A body weight below healthy levels determined by the [Member's] Practitioner;
b) A congenital or acquired condition that places the [Member] at a high risk for development of necrotizing enterocolitis; or
c) A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

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

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the [Member's] Practitioner.

[Note to carrier: Include in EOCs issued or renewed on or after January 1, 2019.]

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

18. Charges for the Treatment of Hemophilia. The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

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

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

19. Colorectal Cancer Screening We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for 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 [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:

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

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

21) Hearing Aids We provide coverage for medically necessary services incurred in the purchase of a hearing aid for a [Member] 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 a 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 medically necessary services incurred in the purchase of a hearing aid.

22) **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 do 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 Contract.

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

[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Network coverage the Contract provides for intravenously administered or injected anti -cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Network copayment, deductible and/or coinsurance for intravenously administered or injected anti -cancer medications the Member 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.]

23) [Contraceptives
We cover prescription female contraceptives which require a Practitioner's prescription and which are approved by the Food and Drug Administration for that purpose. Prescription female contraceptives are covered as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.

As used in this provision, prescription female contraceptive means any drug or device used for contraception by a female. Examples include but are not limited to birth control pills and diaphragms.

With respect to the first dispensing of a specific contraceptive, coverage is provided for a three-month period. For a subsequent dispensing of that same contraceptive, coverage is provided for a six-month period, except as stated below.

Exception: If the six-month period would extend beyond December 31, coverage will be reduced such that the period ends as of December 31.]
[Note to carriers: Omit if requested by a religious employer.]

24) **Vision Benefit** Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover 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.

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

25) **Mammogram Coverage**
We cover mammograms provided to a Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:
a) one baseline mammogram for a Member– who is 40 years of age

b) one mammogram, every year, for a Member age 40 and older; and

c) a mammogram at the ages and intervals the Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

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

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

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

See also the following benefit for Digital Tomosynthesis.

26) Digital Tomosynthesis Charges

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

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

(b) **SPECIALIST DOCTOR BENEFITS** Services are covered when rendered by a [Network] Specialist Doctor at the Practitioner's office or any other [Network] Facility or a [Network] Hospital outpatient department during office or business hours upon prior Referral by a [Member's] Primary Care Provider.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS**. Except as stated below, the following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Provider, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]Facilities subject to Our Pre-Approval); however, [Network] Skilled Nursing Facility Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval.
Exception: If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

1. Semi-private room and board accommodations
Except as stated below, We provide coverage 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 [Member], in consultation with the [Network] Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.
- As an exception to the Medically Necessary and Appropriate requirement of the Contract, We also provide coverage for the mother and newly born child for:

⇒ a minimum of 48 hours of Inpatient care in a [Network] Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of Inpatient care in a [Network] Hospital following a cesarean section.

- We provide childbirth and newborn coverage subject to the following:

⇒ the attending Practitioner must determine that Inpatient care is medically necessary; or
⇒ the mother must request the Inpatient care.

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

2. Private accommodations [will be provided only when approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] Hospice, [Network] Hospital, [Network] Rehabilitation Center or [Network] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services.

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

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

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

20.The following transplants: Cornea, Kidney, Lung, Liver, Heart Pancreas and Intestines.
21.Allogeneic bone marrow transplants.

[22. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the [Member] is participating in a National Cancer Institute sponsored clinical trial.]
[22 or 23. 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;
[23 or 24]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.]
[24. or 25.] Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR MENTAL ILLNESS OR SUBSTANCE USE DISORDER.** Except as stated below for the treatment of Substance Use Disorder, We cover services and supplies for the treatment of Mental Illness or Substance Use Disorder the same way We would for any other Illness, if such treatment is prescribed by a Practitioner.

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

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

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

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

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior Referral by a [Member's] Primary Care Provider in the event of an Emergency as Determined by Us.

I. A [Member's] Primary Care Provider is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member's] health, [Member] shall call a [Member's] Primary Care Provider[or Us] prior to seeking Emergency treatment.
II. We will cover the cost of services and supplies in connection with an Emergency provided within or outside our service area without a prior Referral only if:
A. Our review Determines that a [Member's] symptoms were severe and delay of treatment would have been detrimental to a [Member's] health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
B. The service rendered is provided as a Covered Service or Supply under the Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
C. We and a [Member's] Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. [Member] shall be responsible for payment for services received unless We Determine that a [Member's] failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
III. In the event a [Member] is hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of the Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.

4) Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior Referral or the [Member] shall be responsible for payment.
5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a [Member] is admitted as an Inpatient to the Hospital as a result of the Emergency.
6) 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 Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provides coverage for a medical screening examination provided upon a Member'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 Member has a potentially life-threatening condition. Information on the use of the "911" system is included in the identification card.]

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Provider . Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - 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.
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 Member 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] [Plan] 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 Member who has been diagnosed with a biologically-based Mental Illness, occupational therapy means treatment to develop a Member'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 Member who has been diagnosed with a biologically-based Mental Illness, physical therapy means treatment to develop a Member's physical function.

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

j. *Infusion Therapy* - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion**.**

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

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.
(g) DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another Developmental Disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
a) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
c) speech therapy where speech therapy refers to treatment of a Member's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. 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 Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

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

NOTE: ANY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a [Member]'s Primary Care Provider. When home health care can take the place of Inpatient care, We cover such care furnished to a [Member] under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
2) physical therapy;
3) occupational therapy;
4) medical social work;
5) nutrition services;
6) speech therapy;
7) home health aide services;
8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the [Member] had been in a Hospital; and
9) 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 Contract if performed as Inpatient Hospital services.

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

a. The [Member'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 [Member'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 [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
e. We do not pay for:
1. services furnished to family members, other than the patient; or
2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.
Benefits for Home Health Care are provided for no more than 60 visits per [Calendar] [Plan] Year.

NOTE: ANY HOME HEALTH CARE BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE HOME HEALTH CARE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] SERVICES AND SUPPLIES.

i.) Hospice Care if [Members] are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the [Member's] Primary Care Provider. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(j) **DENTAL CARE AND TREATMENT.**
Dental benefits available to all [Members]

The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care **Provider**. We cover:

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

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the **l**ate**r** of**:**
   a) the date of the Injury; or
   b) the effective date of the Member's coverage under this Contract.

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

[Dental Benefits available to [Members] through end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

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

<u>Diagnostic Services</u>

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

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

<u>Preventive Services</u>

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

a) Dental prophylaxis once every 6 months*

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

Restorative Services

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

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

Endodontic Services

- 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

<u>Orthodontic Services</u>

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

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

Orthodontic service to include:

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

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

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

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 if a stand-alone dental plan is bought. 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 Member who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

(k) **TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Provider. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ We do not cover any services or supplies for orthodontia, crowns or bridgework.

(l)**THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Provider. We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

(m) [CANCER CLINICAL TRIAL We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Member during the course of treatment or a condition associated with a complication of the underlying disease or

treatment, with are consistent with usual and customary patterns and standards of care incurred whenever a Member receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

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

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

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

[NON-NETWORK] BENEFIT PROVISION *APPLICABLE TO [NON-NETWORK] BENEFITS*

The Cash Deductible
Each [Calendar] [Plan] Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by the Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that [Member], less any applicable Coinsurance or Copayments, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while that [Member] is covered by the Contract. And what We pay is based on all the terms of the Contract.

The Contractholder who purchased the Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet the Contract's Cash Deductible if:
a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the [Calendar] [Plan] Year in which the Contract starts;
b) the charges would have been considered Covered Charges under the Contract if the Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in the Contract on its Effective Date; and
d) the Contract takes effect immediately upon termination of the prior plan.

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

[Per Covered Family

The Per Covered Family [Calendar] [Plan] Year Cash Deductible is shown in the Schedule. Once three or more [Members] in a family have incurred a combined total of Covered Charges toward their Per Person Cash Deductible equal to the per Covered Family Cash Deductible, each [Member] in that family will be considered to have met his or her Per Person Cash Deductible for the rest of that [Calendar] [Plan] Year. The Charges that each [Member] in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Person Cash Deductible.]

[The Cash Deductible:
For Single Coverage Only
Each [Calendar] [Plan] Year, a Member must have Covered Services and Supplies that exceed the per Member Cash Deductible before We pay any benefits to the Member for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Services and Supplies above the Deductible amount incurred by the Member, less any applicable Coinsurance, for the rest of that [Calendar] [Plan] Year. But all charges must be incurred while the Member is covered by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.]

[Family Deductible Limit:
For Other than Single Coverage

The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Members in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Services and Supplies incurred by any member of the covered family, less any Coinsurance, for the rest of that [Calendar] [Plan] 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]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a [Calendar] [Plan] 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 Member 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] [Plan] Year.

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Member 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] [Plan] Year.]]
[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

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

[Once any combination of Members in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Member 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] [Plan] Year.]]

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

COVERED CHARGES ***APPLICABLE TO [NON-NETWORK] BENEFITS***

This section lists the types of charges We will consider as Covered Charges and the limits which apply to such Covered Charges. But what We will pay is subject to all the terms of the Contract. Read the entire Contract to find out what We limit or exclude.

Note: Our payments will be reduced if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in the Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a [Member] during the Inpatient confinement. If a [Member] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Except as stated below, We provide coverage 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 [Member], in consultation with the Provider, determine that a shorter length of stay is Medically Necessary and Appropriate.

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

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

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

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

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. The Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

[Emergency Room Copayment Requirement
Each time a [Member] 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 Member 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 Member'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 Member has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

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

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

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

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

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

a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment- drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Member 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 Contract if performed as Inpatient Hospital services.

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

a) The [Member'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 [Member'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.

The home health care plan must be set up in writing by the [Member's] Practitioner within 14 days after home health care starts. And it must be reviewed by the [Member's] Practitioner at least once every 60 days.
We do not pay for:
A. services furnished to family members, other than the patient; or
B. 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] [Plan] Year.

ANY HOME HEALTH CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE HOME HEALTH CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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

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

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

[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. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

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

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

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

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

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

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

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally Ill" or "terminally Injured" means that the [Member's] Practitioner has certified in writing that the [Member'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 [Member]. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of the Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Contract. 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 [Member's] Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

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

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

Mental Illness or Substance Use Disorder
We pay benefits for the Covered Charges a [Member] incurs for the treatment of Mental Illness or Substance Use Disorder the same way We would for any other Illness, if such treatment is prescribed by a Practitioner.

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;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of **T**he Joint Commission;
d) a Mental Health Facility; or
e) a Substance Use Disorder Facility.

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

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and postpartum care in connection with a [Member's] pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

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

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

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

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

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
We cover Medically Necessary and Appropriate charges for transporting a [Member] 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 [Member] to another Inpatient health care Facility.
It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

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

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under the Contract.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member'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 Contract.

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

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

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

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

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

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

Donated Human Breast Milk

We cover pasteurized donated human breast milk for [Members] under the age of six months subject to the following conditions:

a) The [Member] is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the [Member's] mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
b) The [Member's] Practitioner issued an order for the donated human breast milk

We also cover pasteurized donated human breast milk as ordered by the [Member's] Practitioner for [Members] under the age of six months if the [Member] meets any of the following conditions:

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

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

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the [Member's] Practitioner.

[Note to carriers: Include in EOCs issued or renewed on or after January 1, 2019.]

X-Rays and Laboratory Tests

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

Prescription Drugs

[Subject to Our pre-Approval for certain prescription Drugs,]We cover drugs to treat an Illness or Injury which require a Practitioner's prescription. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] And We exclude 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.]

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

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

[If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member 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 Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

[A [Member] 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 Contract 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, We will cover the Covered Service and Supply in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Member is covered. What We pay is subject to all the terms of the [Contract.]

[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We 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 Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Member.]

We 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 Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.]

[The Contract 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 Contract.

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 Member's Practitioner.

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

[[We 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 Us.]

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

[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a Participating Mail Order Pharmacy] from charging the Member 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 Member prior to dispensing the drug.]

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

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

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

Orally Administered Anti-Cancer Prescription Drugs
As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs do 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 Contract.

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

[The anti-cancer prescription drug will be covered subject to the terms of the Prescription Drug provision of the Contract. The Member must pay the copayment, deductible and/or coinsurance required under such Prescription Drug coverage. The Member may then submit a claim for the prescription drug under the Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the Non-Network coverage the Contract provides for intravenously administered or injected anti -cancer medications to determine which is more favorable to the Member in terms of costs incurred for copayments, deductible and/or coinsurance. If the Contract provides different Non-Network copayment, deductible or coinsurance for different places of service, the comparison shall be to location for which the copayment, deductible and coinsurance is more favorable to the Member. If a Member paid a Prescription Drug copayment, deductible and/or coinsurance that exceeds the applicable Non-Network copayment, deductible and/or coinsurance for intravenously administered or injected anti -cancer medications the Member will be reimbursed for the difference.]

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2001, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

[Contraceptives
We cover prescription female contraceptives which require a Practitioner's prescription and which are approved by the Food and Drug Administration for that purpose. Prescription female contraceptives are covered as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.

As used in this provision, prescription female contraceptive means any drug or device used for contraception by a female. Examples include but are not limited to birth control pills and diaphragms.

With respect to the first dispensing of a specific contraceptive, coverage is provided for a three-month period. For a subsequent dispensing of that same contraceptive, coverage is provided for a six-month period, except as stated below.

Exception: If the six-month period would extend beyond December 31, coverage will be reduced such that the period ends as of December 31.]
[Note to carriers: Omit if requested by a religious employer.]

[Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the [Member] 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 [Member] receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

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

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

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

Dental Care and Treatment
Dental benefits available to all [Members]
We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

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

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

[Note to Carriers: The following dental benefits section for members through the end of the month in which the Member turns age 19 would provide non-network dental benefits. Such non-network dental benefits are not required, but may be included at the option of the carrier.]

[Dental Benefits available to [Members] through *the end of the month in which the Member turns age 19*

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.
- 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.

h) *Clinical oral evaluations once* every 6 months *
   6. 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
   7. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   8. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   9. Limited oral evaluations that are problem focused
   10. Detailed oral evaluations that are problem focused

i) Diagnostic Imaging with interpretation
   9. 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.
   10. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   11. Additional films/views needed for diagnosing can be provided as needed.
   12. Bitewings, periapicals, panoramic and cephlometric radiographic images
   13. Intraoral and extraoral radiographic images
   14. Oral/facial photographic images
   15. Maxillofacial MRI, ultrasound
   16. Cone beam image capture

j) Tests and Examinations

k) Viral culture

l) Collection and preparation of saliva sample for laboratory diagnostic testing

m) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

n) Oral pathology laboratory
   4. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   5. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   6. 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.

f) Dental prophylaxis once every 6 months*

g) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

h) Fluoride varnish once every 3 months for children under the age of 6

i) 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.

j) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   5. fixed – unilateral and bilateral
   6. removable – bilateral only
   7. recementation of fixed space maintainer
   8. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.

- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

q) 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.
r) 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
s) 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
t) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
    4. 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
    5. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
    6. Provisional crowns are not covered.
u) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
v) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
w) Core buildup including pins
x) Pin retention
y) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
z) Additional fabricated (custom fabricated/cast) and prefabricated post
aa) Post removal
bb) Temporary crown (fractured tooth)
cc) Additional procedures to construct new crown under existing partial denture
dd) Coping
ee) Crown repair
ff) 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:

p) Therapeutic pulpotomy for primary and permanent teeth
q) Pulpal debridement for primary and permanent teeth
r) Partial pulpotomy for apexogensis
s) Pulpal therapy for anterior and posterior primary teeth
t) Endodontic therapy and retreatment
u) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
v) Apexification: initial, interim and final visits
w) Pulpal regeneration
x) Apicoectomy/Periradicular Surgery
y) Retrograde filling
z) Root amputation
aa) Surgical procedure for isolation of tooth with rubber dam
bb) Hemisection
cc) Canal preparation and fitting of preformed dowel or post
dd) Post removal

<u>Periodontal Services</u>

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

d) Surgical services
    15. Gingivectomy and gingivoplasty
    16. Gingival flap including root planning
    17. Apically positioned flap

18. Clinical crown lengthening
19. Osseous surgery
20. Bone replacement graft – first site and additional sites
21. Biologic materials to aid soft and osseous tissue regeneration
22. Guided tissue regeneration
23. Surgical revision
24. Pedicle and free soft tissue graft
25. Subepithelial connective tissue graft
26. Distal or proximal wedge
27. Soft tissue allograft
28. Combined connective tissue and double pedicle graft

e) Non-Surgical Periodontal Service
   5. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
   6. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
   7. Full mouth debridement to enable comprehensive evaluation
   8. Localized delivery of antimicrobial agents

f) 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:

m) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

n) 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.
   4. Resin base and cast frame dentures including any conventional clasps, rests and teeth
   5. Flexible base denture including any clasps, rests and teeth
   6. Removable unilateral partial dentures or dentures without clasps are not considered

o) Overdenture – complete and partial

p) Denture adjustments –6 months after insertion or repair

q) Denture repairs – includes adjustments for first 6 months following service

r) 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

s) 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

t) Precision attachment, by report

u) Maxillofacial prosthetics - includes adjustments for first 6 months following service
   13. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   14. Obturator prosthesis: surgical, definitive and modifications
   15. Mandibular resection prosthesis with and without guide flange
   16. Feeding aid
   17. Surgical stents
   18. Radiation carrier
   19. Fluoride gel carrier
   20. Commissure splint
   21. Surgical splint
   22. Topical medicament carrier
   23. Adjustments, modification and repair to a maxillofacial prosthesis
   24. Maintenance and cleaning of maxillofacial prosthesis

v) 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.

w) 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

x) 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.

s) Extraction of teeth:
   5. Extraction of coronal remnants – deciduous tooth,
   6. Extraction, erupted tooth or exposed root
   7. Surgical removal of erupted tooth or residual root
   8. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

t) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

u) Other surgical Procedures
   12. Oroantral fistula
   13. Primary closure of sinus perforation and sinus repairs
   14. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   15. Surgical access of an unerupted tooth
   16. Mobilization of erupted or malpositioned tooth to aid eruption
   17. Placement of device to aid eruption
   18. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   19. Surgical repositioning of tooth/teeth
   20. Transseptal fiberotomy/supra crestal fiberotomy
   21. Surgical placement of anchorage device with or without flap
   22. Harvesting bone for use in graft(s)

v) Alveoloplasty in conjunction or not in conjunction with extractions

w) Vestibuloplasty

x) Excision of benign and malignant tumors/lesions

y) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

z) Destruction of lesions by electrosurgery

aa) Removal of lateral exostosis, torus palatinus or torus madibularis

bb) Surgical reduction of osseous tuberosity

cc) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

dd) Surgical Incision
   5. Incision and drainage of abcess - intraoral and extraoral
   6. Removal of foreign body
   7. Partial ostectomy/sequestrectomy
   8. Maxillary sinusotomy

ee) 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.

ff) 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.
   6. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   7. Manipulation under anesthesia
   8. Condylectomy, discectomy, synovectomy
   9. Joint reconstruction
   10. Services associated with TMJD treatment require prior authorization

gg) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

hh) Arthroscopy

ii) Occlusal orthotic device – includes placement and removal to same provider

jj) Surgical and other repairs
   16. Repair of traumatic wounds – small and complicated
   17. Skin and bone graft and synthetic graft
   18. Collection and application of autologous blood concentrate
   19. Osteoplasty and osteotomy
   20. LeFort I, II, III with or without bone graft
   21. Graft of the mandible or maxilla – autogenous or nonautogenous
   22. Sinus augmentations
   23. Repair of maxillofacial soft and hard tissue defects

24. Frenectomy and frenoplasty
25. Excision of hyperplastic tissue and pericoronal gingiva
26. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
27. Emergency tracheotomy
28. Coronoidectomy
29. Implant – mandibular augmentation purposes
30. 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:

j) Limited treatment for the primary, transitional and adult dentition
k) Interceptive treatment for the primary and transitional dentition
l) Minor treatment to control harmful habits
m) Continuation of transfer cases or cases started outside of the program
n) 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.
o) Orthognathic Surgical Cases with comprehensive orthodontic treatment
p) Repairs to orthodontic appliances
q) Replacement of lost or broken retainer
r) 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

m) Palliative treatment for emergency treatment – per visit
n) 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
o) 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

p) Consultation by specialist or non-primary care provider
q) 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

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

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

w) Odontoplasty
x) Internal bleaching]

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, with respect to coverage of TMJ, We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Coverage
We cover mammograms provided to a Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:
We will cover:
d) one baseline mammogram for a Member– who is 40 years of age
e) one mammogram, every year, for a Member age 40 and older; and
f) a mammogram at the ages and intervals the Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

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

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

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

See also the following benefit for Digital Tomosynthesis.

Digital Tomosynthesis Charges

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

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

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

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

High risk for colorectal cancer means a [Member] 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 colorectal cancer screening is included under the Preventive Care provision**.**

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a written home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are not covered.

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

Subject to the stated limits, We cover the Therapy Services listed below**.** We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - 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 Our Pre-Approval,] We cover the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
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 Member 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] [Plan] 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 Member who has been diagnosed with a biologically-based Mental Illness, occupational therapy means treatment to develop a Member'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 Member who has been diagnosed with a biologically-based Mental Illness, physical therapy means treatment to develop a Member's physical function.

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

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

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

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

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Member's primary diagnosis is autism or another Developmental Disability We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:
d) occupational therapy where occupational therapy refers to treatment to develop a Member's ability to perform the ordinary tasks of daily living;
e) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
f) speech therapy where speech therapy refers to treatment of a Member's speech impairment.
Coverage for occupational therapy and physical therapy combined is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per [Calendar] [Plan] Year for the treatment of conditions other than autism. 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 Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

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

If a Member:
d) is eligible for early intervention services through the New Jersey Early Intervention System; and
e) has been diagnosed with autism or other Developmental Disability; and
f) 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 Contract. 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 Member 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.

NOTE: ANY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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

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

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

Immunizations and Lead Screening
We will cover charges for:

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

Hearing Aids

We cover charges for medically necessary services incurred in the purchase of a hearing aid for a [Member] 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 medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

Newborn Hearing Screening

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

Vision Screening

We cover vision screening for Dependent children, through age 17, to determine the need for vision correction. . The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the [Member] should undergo a vision examination.

Vision Benefit

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Covered Persons through end of the month in which the Member turns age 19. We cover 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.

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

Therapeutic Manipulation

We limit what We cover for therapeutic manipulation to 30 visits per [Calendar] [Plan] Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) [Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:

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

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

[h) 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;
i) 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 Contract will cover the donor's costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THE CONTRACT.

[Abortion, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.]

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** with respect to all [Non-Network] benefits.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a [Member].

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 Contract; 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 Contract.

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

Services or supplies, the primary purpose of which is **educational** providing the [Member] 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 Contract.

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

Extraction of teeth, except for bony impacted teeth except as otherwise covered under this Contract..

Services or supplies for or in connection with:

a. except as otherwise stated in the Contract, 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 this Contract 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: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian 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 otherwise stated in the Hearing Aids and Newborn Hearing Screening provisions, services or supplies related to **hearing aids and hearing examinations** 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 [Member] 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, and related services.**

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment**, except as otherwise stated in the Preventive Care section of the Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** specifically limited or not covered elsewhere in the Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;
a) insulin needles and insulin syringes and glucose test strips and lancets;
b) colostomy bags, belts, and irrigators; and
c) as stated in the Contract 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 official or practitioner.

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

[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- 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 Member, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Use Disorder Facility
- a Mental Health Facility
- a convalescent home
- a nursing home or similar institution
- a provider' 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 Member taking part in a riot or other civil disorder; or the

o)Member 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 Member 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 Member'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 We are legally required to pay it, We will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract

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 Members 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.]

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Provider** except as specified in the Contract.

Services related to **Private Duty Nursing** care, except as provided in the Home Health Care sections of the Contract.
Services or supplies that are not furnished by an eligible **Provider**.
Services or supplies related to **rest or convalescent cures**.

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

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of the Contract, **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; or pre-marital 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 or supplies:

a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] 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 [Member] 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 this Contract and under military health coverage and who receive care in facilities of the Uniformed Services.

e) provided outside the United States unless the [Member] 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 [Member] is temporarily outside the United States for a period of 6 months or less; and
- Subject to Our Pre-Approval, eligibility for full-time student status, provided the [Member] 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 a 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..**

Services provided by a **Social Worker**, except as otherwise stated in the Contract.

Stand-by services required by a Provider**.**

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

[Telephone consultations. except as stated in the Outpatient Services provision.]
Transplants, except as otherwise listed in the Contract.

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 Member 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 Member is serving in such forces and is outside the home area.

Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the surgery sections of the Contract 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.

[IMPORTANT NOTICE ***APPLICABLE ONLY TO [NON-NETWORK] BENEFITS***

[The Contract has utilization review features which are applicable to **[Non-Network]** benefits. Under these features, [ABC - Systems, a health care review organization] reviews Hospital and other Facility admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a [Member]:

a) is admitted as an Inpatient to a Hospital or other Facility, or

b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under the Contract. See the **Utilization Review Features** section for details.]

[The Contract has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a [Member'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 Contract has Centers of Excellence features. Under these features, a [Member] may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

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

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

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with the Contract's utilization review features, he or she will not be eligible for full benefits under the Contract.

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

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under the Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of the Contract.

Definitions

"Hospital admission" means admission of a [Member] to a Hospital or other Facility as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

By "covered professional charges for Surgery" We mean charges for 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 Contract is not payable under the Contract.

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

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

[REQUIRED FACILITY STAY REVIEW

Important Notice: If a [Member] does not comply with these Facility stay review features, he or she will not be eligible for full benefits under the Contract.

Notice of Facility Admission Required
We require notice of all Hospital or other Facility admissions. The times and manner in which the notice must be given is described below. When a [Member] does not comply with the requirements of this section We reduce what We pay for covered Hospital or other Facility charges as a penalty.

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

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

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

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

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

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

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] group plan number;
c) the reason for the admission
d) the name and location of the Hospital or other Facility

e) when the admission occurred; and
f) the name of the [Member's] Practitioner.

Continued Stay Review
The [Member] 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 [Member], or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital or other Facility stay. This must be done before the end of the previously authorized length of stay.

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

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

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.
[ABC] notifies the [Member'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 admission, as a penalty for non-compliance. [We reduce what We pay for covered Facility charges, **by 50%]** if**:**
a) the [Member] or his or her Practitioner does not request a pre-admission review; or
b) the [Member] or his or her Practitioner does not request a pre-admission review as soon as reasonably possible before the admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the [Member] or his or her Practitioner does not obtain a new one; or
d) [ABC] does not authorize the admission.

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

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

For any Hospital or other Facility admission, if a [Member] stays in the Hospital or other facility longer than [ABC] authorizes, We reduce what We pay for covered charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.
Penalties cannot be used to meet the Contract's Maximum Out of Pocket or Cash Deductible.

[REQUIRED PRE-SURGICAL REVIEW

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

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

The [Member] 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 [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] may obtain a second surgical opinion. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] 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 [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

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

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

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

Penalties for Non-Compliance
As a penalty for non-compliance, [We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the [Member] 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 [Member] 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 Contract's Maximum Out of Pocket or Cash Deductible.

[SPECIALTY CASE MANAGEMENT

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

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

Please note: We have Discretion to determine whether to consider Specialty case Management for a [Member.]

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) Substance Use Disorder
l) Mental Illness
m) any other Illness or Injury Determined by [DEF] or Us to be catastrophic.

Specialty Case Management Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] 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 [Member], [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 [Member], or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Specialty Case Management Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;

c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] 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 or Covered Services and Supplies, as appropriate, under the terms of the Contract.

The agreed upon Specialty Case Management treatment must be ordered by the [Member's] Practitioner.

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

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

[CENTERS OF EXCELLENCE FEATURES

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

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

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to Determine whether the [Member] 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 considered as 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 [Member].

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Contract] 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 Us to coordinate what We pay 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 [Member] 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 [Member] 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 [Contract] 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 [Contract] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We 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 Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Claim Determination Period: A [Calendar] [Plan] Year, or portion of a [Calendar] [Plan] Year, during which a [Member] is covered by this [Contract] 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 [Member] 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 [Member'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 "a" or "b" below exists:

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 [Member] 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 [Member] 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

We consider 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 [Member] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Member] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Member] 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 [Member] 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 [Member] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Member] 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] [Plan] Year shall be determined before those of the parent whose birthday falls later in the [Calendar] [Plan] 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] [Plan] 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 [Member] 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 [Member] 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 [Member] 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, EPO or other plans pays the provider a fixed amount per [Member]. The [Member] is liable only for the applicable deductible, coinsurance or copayment. If the [Member] 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 .

<u>Primary Plan is an AC Plan and Secondary Plan is an AC Plan</u>
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

<u>Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan</u>
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the [Member] shall not exceed the fee schedule of the Primary Plan. In no event shall the [Member] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

<u>Primary Plan is an AC Plan and Secondary Plan is Fee Schedule Plan</u>
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 [Member] shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the [Member] 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 [Member] 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 [Member] 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 [Member] 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 [Member] 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 [Member] 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 [Member] 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.

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a [Member's] coverage under the Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

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

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

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

"Eligible Services or Expenses" means services or expenses provided for treatment of an Injury which is covered under the Contract 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 Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the [Member] under the Contract. 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 Contract may be primary for one [Member], but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

The Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case the Contract will be primary.

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

Services and Benefits the Contract will provide if it is primary to PIP or OSAIC.
If the Contract is primary to PIP or OSAIC it will provide **services and** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of the Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits the Contract will pay if it is secondary to PIP or OSAIC.
If the Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if the Contract had been primary.

Medicare
If the [Non-Network] benefits under the Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

CLERICAL ERROR - MISSTATEMENTS
Except as stated below, neither clerical error nor programming or systems error by the Contractholder, nor Us in keeping any records pertaining to coverage under the Contract, 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 Contractholder 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 Contract, such return of premium will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

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

If a Contractholder continues to pay the full premium for a [Member] who is no longer eligible to be covered the Contractholder may request a refund of premium as explained in the Premium Refunds provision of the Contract. If We refund premium to the Contractholder the refund will result in the retroactive termination of the [Member'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.

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

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

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

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

LIMITATION ON ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after a [Member] 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.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at [Our] [XYZ's] office [or to one of our authorized agents.] A premium payment is due on each premium due date stated on the first page of this Contract. The Contractholder 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 Contractholder is liable to pay premiums for the time this Contract is in force.] *[Note to carriers: include the previous sentence regarding liability for premiums for contracts issued outside the SHOP]* [If the premium is not paid by the end of the grace period the Contract will terminate as of the paid-to-date.] *[Note to carriers: include the previous sentence regarding termination as of the paid-to-date for contracts issued inside the SHOP]*

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

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

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

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

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

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

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

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the [Member's] death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [For covered services from an eligible Facility or Practitioner, We will Determine to pay either the [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Contract to such provider. [We use reimbursement policy guidelines that were developed through evaluation and validation of standard billing practices as indicated in the most recent edition of the Current Procedural Terminology (CPT) as generally applicable to claims processing or as recognized and utilized by Medicare. We apply these reimbursement policy guidelines to determine which charges or portions of charges submitted by the Facility or the Practitioner are Covered Charges under the terms of the Contract.]

PHYSICAL EXAMS
We, at Our expense have the right to examine the [Member]. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

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 [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A [Member] 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 Contract:

If a [Member] elects to continue his or her group health benefits under this Contract'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 [Member]:
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 Contract. 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 Contract 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 Contract 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 Contract, 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 Contract, 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 Contract'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 Contract 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 Contract 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 Contract 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 Contract, 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 Contract'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 Contract'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 Contract 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 Us 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 the Contractholder's Anniversary Date 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 Contract [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 covered by the Contract 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 covered 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 Contract 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, covered under the Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.
We 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 Us 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, Us.

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 [Member] 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 Contract 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 Contract.

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 plan. 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 medical care coverage will be continued. Dependents' coverage 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
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total 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 covered under the Contract 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 Contract.]

[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 termination of the domestic partnership], the group health coverage for his or her former spouse ends. The former spouse may convert to an individual Contract during the conversion period. The former spouse may cover under his or her individual Contract any of his or her Dependent children who were covered under the Contract on the date the group health coverage ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
c) [•if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual Contract in writing and pay the first premium for such Contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT
The individual Contract will provide the medical benefits that We are required to offer. The individual Contract will take effect on the day after group health coverage under the Contract ends.

After group health coverage under the Contract ends, the former spouse and any children covered under the individual Contract may still receive benefits under the Contract. If so, benefits to be paid under the individual Contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under the Contract.]

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. 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 Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how the Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] 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 [Member] 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 [Member] 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 [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

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 covered 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 covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered 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 Contract 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 Contract 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 Contract 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, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When the Contract is primary
When a Medicare eligible chooses the Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and 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 Contract. Coverage under this Contact 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 Contract 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 [Member] 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 [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:

a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease or
c) a [Member] who is the Employee's civil union partner [or domestic partner] or the child of the Employee's civil union partner [or domestic partner]..

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, the Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare be 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 and Services** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] 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 services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and 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 [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] 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 and Services** section of the Contract.

[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 FOR [NON-NETWORK] BENEFITS
Carriers should include claims procedures consistent with the requirements of ERISA.]

[Carriers may include additional information consistent with the requirements of 29 C.F.R. 2590.715 – 2715.]