

**CHAPTER 38**

**HEALTH MAINTENANCE ORGANIZATIONS**

**Authority**

N.J.S.A. 26:2H-1 et seq.

**Source and Effective Date**

R.1997 d. 68, effective January 17, 1997.  
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 38, Health Maintenance Organizations, expires on January 17, 2002.

**Chapter Historical Note**

Chapter 38, Health Maintenance Organizations, was adopted as R.1974 d.320, effective November 20, 1974. See: 6 N.J.R. 8(b), 6 N.J.R. 473(a). Pursuant to Executive Order No. 66(1978), Chapter 38 expired on April 3, 1994.

Chapter 38, Health Maintenance Organizations, was adopted as R.1994 d.365, effective July 18, 1994. See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a). Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, was adopted as R.1996 d.194, effective April 15, 1996. See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. See: Source and Effective Date. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider Network, Subchapter 7, Continuous Quality Improvement, Subchapter 8, Utilization Management, Subchapter 9, Member Rights and Responsibilities, Subchapter 10, Medical Records, Subchapter 11, Financial Standards and Reporting, Subchapter 12, Rehabilitation, Conservation and Liquidation, Subchapter 13, Licensing of Representatives and Advertising, and Subchapter 15, Provider Agreements and Risk Transference, were adopted as new rules. New rules 8:38-3.5(a)4; 8:38-3.6(e); 8:38-4.1(b); 8:38-5.3(b)5; 8:38-6.3(a)3i; 8:38-8.1(a)7; 8:38-8.2(a) and (c); 8:38-8.3(b) and (d); 8:38-8.4(b); 8:38-8.6(f); 8:38-8.7; 8:38-8.8; 8:38-9.1(c)1, 8 and 12; and 8:38-13.4, became operative March 15, 1997; all repeals, amendments, and other new rules became operative July 1, 1997.

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**SUBCHAPTER 1. SCOPE AND DEFINITIONS**

**8:38-1.1 Scope**

(a) The rules in this chapter were developed by the Commissioner of Health and Senior Services in collaboration with the Commissioner of Banking and Insurance and govern the establishment and operation of health maintenance organizations in New Jersey pursuant to the authority set forth in N.J.S.A. 26:2J-1 et seq. These rules are only applicable to managed care plans that constitute a health maintenance organization as defined herein and in N.J.S.A. 26:2J-1 et seq.

(b) The provisions of these rules shall apply, except where in conflict with:

1. Any individual contract issued by a health maintenance organization (HMO) to the extent that the contract is formulated in accordance with the provisions of the New Jersey Individual Health Coverage Program established pursuant to N.J.S.A. 17B:27A-1 et seq.; or

2. Any contract issued to a small employer by a HMO to the extent that the contract is formulated in accordance with the provisions of the New Jersey Small Employer Health Coverage Program established pursuant to N.J.S.A. 17B:27A-17 et seq.

(c) The provisions of these rules shall apply to any services of the HMO which are subcontracted to other entities.

(d) Nothing contained in these rules shall be construed to limit the authority of the Division of Medical Assistance and Health Services of the Department of Human Services to impose, in any contract to provide HMO services to New Jersey Medicaid recipients, standards that exceed those set forth in this chapter.

**8:38-1.2 Definitions**

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Authorized payor” means a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing a health insurance business, a hospital service corporation, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society.

“Basic comprehensive health care services” means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 8:38-5, including all services listed at N.J.A.C. 8:38-5.2.

“Capitation” means a fixed payment for the provision of medical services not based on frequency or severity of services or supplies provided.

“Carrier” means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E-1 et seq.

“Claims” means a request for payment of charges for services rendered or supplies provided by a provider to a member.

“Clean claim” means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim.

“Commissioner” means the State Commissioner of Health and Senior Services or his or her designee.

“Commissioner of Banking and Insurance” means the Commissioner of the New Jersey Department of Banking and Insurance or his or her designee.

“Consumer Price Index” or “CPI” means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined as published by the Commissioner of Banking and Insurance in the New Jersey Register.

“Contested claim” means a claim that has not been adjudicated because it has a material defect or impropriety.

“Continuous quality improvement” means an ongoing and systematic effort to measure, evaluate, and improve an organization’s process to continually improve the quality of health care services provided to members.

“Contract holder” means an employer or organization which purchases a contract for services.

“Department” means the New Jersey Department of Health and Senior Services.

“Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably 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 the unborn child.

“Evidence of coverage” means a statement of the essential features and services of the HMO coverage which is given to the subscriber by the HMO or by the group contract holder.

“External quality review organization (EQRO)” means an organization approved by the Department pursuant to this chapter to perform external quality audits of HMOs.

“Financial incentive arrangement” means a formal mechanism instituted by an HMO or a secondary contractor that exposes a provider, or group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

“Financial risk” means participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.

“GAAP” means Generally Accepted Accounting Principles.

“Gatekeeper system” means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is rendered by the member’s primary care provider, or the member’s access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO’s contract with the subscriber or contractholder.

“Group health contract” means a contract, filed by or with the New Jersey Department of Banking and Insurance or the Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term “group health contract” shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Banking and Insurance, or determined incomplete by the

Small Employer Health Benefits Program Board of Directors, as appropriate.

“Health care expenditures” means the cost, on an incurred basis, of health care services and supplies rendered by a participating provider or a nonparticipating provider which are the responsibility of the HMO in accordance with the contracts the HMO has issued to contract holders.

“Health center” means a facility owned or leased by an HMO, used by members to receive medical and ancillary services including but not limited to: lab, radiology, and pharmacy.

“Health maintenance organization (HMO)” means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to members.

“Indemnity” means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

“Independent utilization review organization (IURO)” means an independent organization, comprised of physicians and other health care professionals representative of the active practitioners in New Jersey, with which the Department contracts in accordance with N.J.A.C. 8:38-8.8 to conduct independent medical necessity or appropriateness of services appeal reviews brought by a member or provider on behalf of the member, with the member’s consent.

“Insurer” means any insurance company authorized to transact the business of insurance in New Jersey.”

“Managed hospital payment” means agreements between the HMO and a hospital under which the financial risk primarily related to the degree of utilization rather than to the cost of services is transferred to the hospital.

“Master policy” means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

“Medicaid marketing representative” means any person who is registered as a limited insurance representative pursuant to N.J.S.A. 17:22A-16 and who is authorized to solicit, negotiate or effect contracts with Medicaid recipients as an agent for a Medicaid-contracting HMO, and performs no other service for the HMO that would otherwise require that person to be authorized and licensed as an insurance producer.

“Medical screening examination” means an examination and evaluation within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel pursuant to requirements in N.J.A.C. 8:43G-12, which are necessary to determine whether or not an emergency medical condition exists.

“Member” means an individual who is enrolled in an HMO.

“Network” means all participating providers under contract or other agreement acceptable to the Department to furnish health care services to members of the HMO.

“Net worth” means the excess of the admitted assets over total liabilities of an HMO.

“Out-of-network covered services” means indemnity benefits for covered services rendered to an HMO member by someone other than the HMO’s contracted health care providers.

“Participating provider” means a provider which, under contract or other arrangement acceptable to the Department with the HMO or with its contractor or subcontractor, in accordance with the provisions of this chapter, has agreed to provide health care services to members with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from the HMO.

“Person” means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

“Plan documents” mean contract, evidence of coverage, certificate, and member handbook, collectively.

“Point of service contract” means a contractual arrangement between an HMO and a member, subscriber or contract holder whereby the HMO makes provision for the rendering of covered services to its members through a network of health care providers as well as an out-of-network covered services option.

“Primary care provider (PCP)” means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care and meets the qualifications in N.J.A.C. 8:38-6.2.

“Primary contractor” means a provider that agrees directly with an HMO to provide one or more services or supplies directly to an HMO’s members.

“Provider” means a physician or other health care professional, hospital facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

“Reinsurance-type contract” means a contract between an insurer and an HMO whereby the insurer agrees to indemnify the HMO for all expenses incurred by the HMO’s members under a POS contract for out-of-network covered services, and further, the insurer agrees that it will indemnify the HMO’s members for expenses incurred for out-of-network covered services for the duration of the period for which premiums are or have been paid by the contract holders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation.”

“SAP” means Statutory Accounting Practices.

“Secondary contractor” means a person who agrees to arrange for the provision of one or more services or supplies for an HMO’s members. A primary contractor may also be a secondary contractor when acting as a broker or administrator for the rendering of services or supplies that, in scope of licensure, type or quantity, the primary contractor (provider) alone could not offer directly to members.

“Secondary network” means a distinct delivery system developed by an HMO to be offered with one or more of its products in addition to, as an alternative to, or a substitute for, the delivery system(s) for which the HMO obtained its initial certificate of authority.

“Service area” means the geographic area for which the HMO has been issued a certificate of authority, in accordance with this chapter.

“Subscriber” means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued.

“Uncovered health care expenditures” means costs to the HMO for health care services that are the obligation of the HMO for which a member may be liable in the event of an HMO’s insolvency and for which no alternative arrangements (that guarantee, insure or provide assumption by a person or organization other than the HMO for the provision of services or benefits) have been made that are acceptable to the Commissioners of Health and Senior Services and Banking and Insurance.

“Urgent care” means a non-life-threatening condition that requires care by a provider within 24 hours.

“Utilization management” means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a member should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review,

discharge planning, preauthorization or ambulatory care procedures and retrospective review.

Public Notice: Increase in medical component of the Consumer Price Index.

See: 29 N.J.R. 2484(b).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 30 N.J.R. 1330(a).

Amended by R.1998 d.458, effective September 8, 1998.

See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).

Inserted “Claims”, “Clean claim” and “Contested claim”.

Public Notice: Increase in medical component of the Consumer Price Index.

See: 31 N.J.R. 801(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 32 N.J.R. 1259(a).

Amended by R.2000 d.183, effective May 1, 2000.

See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

In “Emergency”, substituted “a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to” for “absence of immediate medical attention could reasonably” following “such that” in the first sentence; in “Health maintenance organization (HMO)”, substituted a reference to members for a reference to enrollees; rewrote “Independent utilization review organization (IURO)” and “Utilization management”; inserted “Plan documents” and “Secondary network”; and in “Provider”, inserted a reference to other health care professionals.

#### Case Notes

Health maintenance organization’s (HMO’s) asset purchase agreement with for-profit corporation and health services agreement with limited liability corporation that was to facilitate administration of medical services to HMO enrollees were not contracts with providers as required for confidentiality under the HMO Act; corporations not “providers” since they were not authorized to furnish health care services and internal management of HMO still maintained ultimate responsibility for the affairs of the HMO. *HIP of New Jersey, Inc. v. New Jersey Dept. of Banking and Ins.*, 707 A.2d 1044, 309 N.J. Super. 538.

## SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

### 8:38-2.1 Certificate of need and licensing

Any health maintenance organization (HMO) which proposes the establishment and/or operation of a health care facility or any change in or expansion of a health care facility, or the institution of new health care services as defined in the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) shall comply with all pertinent provisions of the Act, as amended and N.J.A.C. 8:33, Certificate of Need application and Renewal process, and all applicable health planning and licensing rules and regulations.

### 8:38-2.2 Application for a new or amended certificate of authority

(a) Any person, organization or corporation desiring to establish and/or operate an HMO shall apply to the Commissioner for a certificate of authority, pursuant to N.J.S.A.

26:2J-1 et seq. Applications for a certificate of authority may be obtained from:

New Jersey State Department of Health and Senior Services  
Office of Managed Care  
PO Box 360  
Trenton, NJ 08625-0360

or

New Jersey Department of Banking and Insurance  
Managed Care Bureau  
Life and Health Division  
20 West State Street  
PO Box 325  
Trenton, NJ 08625-0325

1. Two copies of the entire application shall be submitted to the Department at the above address;

2. One copy of the entire application (excluding signed provider agreement pages) shall be submitted to the Department of Banking and Insurance at the above address; and

3. If the applicant proposes to be a Medicaid program participant, one copy of the application shall be submitted to:

New Jersey Department of Human Services  
Office of Managed Health Care  
Division of Medical Assistance and Health Services  
PO Box 712  
Trenton, NJ 08625-0712

(b) The applicant shall submit to the Department a non-refundable fee of \$100.00, or as specified in N.J.S.A. 26:2J-23, as may be amended, payable to the New Jersey Department of Health and Senior Services for the filing of an application for a certificate of authority as an HMO, or for any renewal or amendments thereto.

(c) The application for a certificate of authority shall be deemed complete only when filed on forms prescribed by the Department and when accompanied by the following:

1. A copy of the basic organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

2. A copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of persons who are to be responsible for the conduct of the affairs of the HMO including names, addresses, official positions and a biographical affidavit for each person, including all officers and directors;

4. A specimen copy of the contract between the HMO and each participating provider, and an attestation by the HMO's CEO as to the execution of contracts by participating providers consistent with the information submitted by the HMO to demonstrate network adequacy and made in accordance with N.J.A.C. 8:38-15, including a description of any compensation program involving incentive or disincentive payment arrangements permitted under the laws of this State. As required by N.J.S.A. 26:2J-26, any copies of any contract made between the HMO and any provider, insurer, hospital or medical service corporation shall be considered confidential;

i. Executed signature pages shall be made available to the Department or Department of Banking and Insurance upon request, but such documents shall otherwise remain confidential;

5. A copy of any merger or acquisition documents of the applicant or the applicant's parent if the merger or acquisition is with respect to the parent, management agreements for administrative services, and asset sale agreements.

6. A copy of the form of evidence of coverage to be issued to the subscriber;

7. A copy of the form of the individual and group contract, if any, which is to be issued to subscribers and contract holders;

8. The most recent audited financial statements (or other documentation as specified by N.J.A.C. 8:38-11 for newly-formed applicants) showing the applicant's assets, liabilities, sources of financial support, a statement as to the sources of funding and all other financial requirements as delineated in N.J.A.C. 8:38-11;

9. A description of the proposed method of marketing and financing;

10. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served;

11. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

12. Enrollment projections presented on a quarterly basis for the first three years of operation for each county or sub-area proposed as the service area. The enrollment projections should be accompanied by a description of the demographic characteristics of the population, including at least sex and age;

13. A description of the methods used by the HMO to facilitate access to services for culturally and linguistically diverse members;

8. A description of continuation of coverage for those individuals who are in a health care facility at the time of termination of the group contract;

9. A description of how coverage under the health benefits plan may be continued pursuant to applicable Federal or State law (COBRA and/or N.J.S.A. 17B:27A-27) in the event of both member termination and group termination;

10. A description of the extension of benefits for those members who become totally disabled; and

11. A description of the service area.

#### 8:38-17.4 Specific standards for required provisions

(a) With respect to information about the HMO, the name, address and telephone number of the HMO shall be included, with a telephone number by which members may contact the HMO without incurring toll charges.

(b) With respect to eligibility requirements, the plan documents shall state what conditions must be met in order to enroll as a subscriber or a subscriber's dependent, the limiting age for subscribers and dependents, if any, including the effects of Medicare upon continued eligibility of the subscriber or dependent for some or all of the covered services under the health benefits plan, and a clear statement regarding the coverage of newborns.

1. The statement regarding newborns shall be consistent with N.J.A.C. 8:38-3.2.

2. There shall be a provision regarding special enrollment periods for employees and dependents, consistent with the requirements of the Health Insurance Portability and Accountability Act, Pub. L. 104-191, and the laws of this State regarding group health insurance, N.J.S.A. 17B:27-54 et seq.

3. All other provisions regarding eligibility shall be consistent with Federal and State laws, including eligibility of children also eligible for Medicaid, and dependency established as a matter of court order.

(c) With respect to the description of benefits and services, the descriptions shall be consistent with the rules in this chapter regarding required benefits and services, emergency services, and out-of-area services, and shall set forth any limitations and exclusions that may apply with respect to services and the receipt of services.

1. Statements regarding limitations and exclusions shall include any limitations or exclusions due to preexisting conditions, waiting periods or affiliation periods, or a member's refusal of treatment.

2. In no instance shall an HMO include statements in the plan documents requiring or suggesting that a member may only obtain emergency services through a participating or otherwise affiliated provider.

(d) With respect to member termination, the provision shall not be inconsistent with N.J.A.C. 8:38-3.4, nor may the HMO cancel or nonrenew a member's coverage solely on the basis of the items set forth at N.J.A.C. 8:38-3.2(a).

(e) With respect to the claims processing information, the information shall include, but not be limited to, the requirements for filing proper proof of loss, any time limit on the filing of claims or payment of claims, explanations of how disputed claims may be resolved, any restrictions on assignment of a claim, and whether a standard claim form is required to be used.

(f) With respect to the continuation of coverage of a member when the member is admitted to the health care facility on the date that the group health benefits plan is terminated, the provision shall specify that the HMO shall continue to provide benefits for the member until the date of the member's discharge from the health care facility, or exhaustion of the member's benefits under the terms of the health benefits plan, whichever occurs first, and in no event shall the provisions be inconsistent with the standards of N.J.A.C. 11:2-13.

(g) With respect to coordination of benefits, if the HMO will coordinate benefits under the health benefit plan, the HMO shall comply with N.J.A.C. 11:4-28; otherwise, the HMO shall include a statement that coverage under the health benefits plan shall be primary coverage for all members.

(h) With respect to the extension of benefits for total disability, the provisions shall not be inconsistent with N.J.S.A. 17B:27-51.12.

(i) With respect to the entire contract provision, the HMO shall include a statement that the contract, all applications and any amendments thereto constitute the entire agreement between the parties, and the HMO shall not include any portion of its charter, bylaws or other documents as part of the contract or plan document unless set forth in full in the contract or attached to it.

(j) With respect to the term of the coverage, termination of the group contract and renewal, the HMO shall include a provision that specifies the date or occurrence upon which coverage becomes effective, the anniversary date of the contract, conditions upon which cancellation or termination may be effected by the HMO, the contractholder and/or the subscriber, and the conditions for and any restrictions upon renewal.

(k) With respect to the grace period, the HMO shall provide for a grace period of no less than 30 days for the payment of any premium other than the initial premium, during which time the coverage shall remain in effect.

1. The provision shall specify that the HMO shall remain liable for providing the services and benefits covered under the health benefits plan, the contractholder

remains liable for payment of the required premium, and the members remain liable for any copayments, deductibles, coinsurance or other costs that may be applicable under the terms of the health benefits plan.

2. The provision shall specify that if the premium is not paid during the grace period, coverage is automatically terminated at the end of the grace period, effective as of the end of the grace period, and that the HMO shall provide notice of the effective date of the termination to the contractholder no more than 30 days following the effective date of the termination.

(l) With respect to the conformity of law provision, the HMO shall provide that any portion of the contract that is not otherwise in conformity with the laws of this State, including but not limited to, N.J.S.A. 26:2J-1 et seq., 26:2S-1 et seq., and rules promulgated pursuant thereto, and 17B:27-49 et seq., as amended by P.L. 1997, c. 146, shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this State.

**8:38-17.5 Standards for optional provisions**

(a) If an HMO intends to coordinate benefits under the health benefits plan, the plan documents shall include a statement specifying that coordination may occur, and an explanation of how coordination will be achieved.

1. Coordination of benefits shall be accomplished in accordance with N.J.A.C. 11:4-28, and the explanation of coordination of benefits shall not be inconsistent with those rules.

2. If an HMO fails to include a provision regarding coordination of benefits consistent with N.J.A.C. 11:4-28, the health benefits plan shall be primary coverage for all members.

(b) If an HMO will allow reinstatement of the group health benefits plan, and/or coverage for a member, the plan documents shall include any terms and conditions for reinstatement.

(c) If an HMO may seek subrogation for injuries caused by third parties, the plan documents shall contain a provision setting forth the HMO's intent, but the provisions shall not be inconsistent with N.J.A.C. 8:38-11.9.

**8:38-17.6 Compliance**

Forms of plan documents in effect on May 1, 2000 shall be deemed withdrawn on May 1, 2001 if not in compliance with this subchapter.

**APPENDIX**

**Exhibit 1**

**Notice of Contested Claim**

The information below is with respect to a single patient (see Part B) identified on a claim filed by your office with us on \_\_\_/\_\_\_/\_\_\_\_. Those services marked with an asterisk (\*) under the column "HMO Payment" are contested. The reasons for which the claim, or a portion of the claim, is contested and the information we need to make a final determination on the claim are set forth in Part D. Please contact the individual(s) identified in Part E if you have additional questions regarding this notice. If there are portions of a claim which we are not contesting, the "HMO Payment" column indicates the amount we are paying or will pay you for the services rendered, and the "Patient Copay" column indicates whether a copayment should have been collected by you from the patient. The information contained in Parts A, B and C are derived from the claim filed by your office.

**Part A: Service information**

	Procedure codes	Date of service	Provider	Billed amount	HMO Payment	Patient Copay
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

**Part B: Patient Information**

Name: \_\_\_\_\_

**Part C: Provider Information**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: M / F HMO ID: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 Subscriber Name and SSN: \_\_\_\_\_

Patient Acct # (if any): \_\_\_\_\_

**Part D: Reasons for contesting the claim, or portion of a claim, and additional information needed**

Specific services, if listed, are listed by number in the order stated in Part A:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional pages are attached.

**Part E: HMO and Contact Person Information**

HMO Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ Title (as applicable): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

New Rule, R.1998 d.458, effective September 8, 1998.  
 See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).