

CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

R.2006 d.15 and d.16, effective December 7, 2005.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a);
37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on December 7, 2010.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rule-making, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq.* See: 35 N.J.R. 2898(a).

Subchapter 22, Basic and Essential Health Care Services Plan, was adopted as R.2003 d.91, effective January 28, 2003. See: 34 N.J.R. 73(a), 35 N.J.R. 1290(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

Subchapter 4, Standard Application Form; Subchapter 5, Standard Claim Form and Appendix Exhibits G, H, and I, expired effective July 4, 2005. See: 37 N.J.R. 2994(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits Q, R, and T were repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23, Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. See: Source and Effective Date. See, also, section annotations.

Case Note

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), deleted "or the Department" following "of the Board" in the second sentence.

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998

(a) The IHC Program Board may assess members for reimbursable net paid losses as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A-11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for the preceding two-year calculation period based upon the information submitted by members no later than March 1 of the year immediately following each two-year calculation period to the IHC Program Board in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K in the Appendix to this chapter, completed in accordance with N.J.A.C. 11:20-8. Such a determination shall be made by the IHC Program Board on or about May 1 of the year immediately following each two-year calculation period.

1. The total reimbursable net paid losses of the preceding two-year calculation period shall be the aggregate of the reimbursable net paid losses for all members reporting net paid losses for that two-year calculation period.

2. Prior to receiving reimbursement for net paid losses, a member must meet the performance standards set forth at N.J.A.C. 11:20-10.

(c) The Board shall determine each member's assessment amount by multiplying the member's market share, or adjusted market share as applicable, by the total reimbursable net paid losses for the preceding two-year calculation period. The portion of assessment amounts forgiven to those members granted a final (full or pro rata) exemption shall be redistributed to carriers not receiving a final (full or pro rata) exemption as described in (c)3 below. Assessment amounts for those members granted a deferral by the Commissioner shall be redistributed as described in (c)2 below.

1. The IHC Program Board shall determine each member's market share by comparing the member's net earned premium for all health benefits plans for the preceding two-year calculation period to the net earned premium of all members for the preceding two-year calculation period as reported by each member in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K of the Appendix to this chapter, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit a Carrier Market Share and Net Paid Gain (Loss) Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program based upon the premium set forth in the member's most recent Annual Statement filed with the Department. Members' market

shares shall be adjusted in consideration of the following factors, if necessary:

i. A member that has been granted a full exemption under N.J.A.C. 11:20-9.5 shall not be assessed for any portion of the total reimbursable net paid losses.

ii. A member that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall be liable for an assessment determined by multiplying the total amount of reimbursable losses (program losses) for the preceding two-year calculation period by the ratio of the member's net earned premium to the net earned premium of all members for the preceding two-year calculation period multiplied by a fraction, the numerator of which is the difference between the minimum number of non-group persons allocated to the member by the Board and the number of non-group persons actually enrolled or insured by the member, taking into account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and the denominator of which is the minimum number of non-group persons allocated to the member by the Board. A carrier that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall not be liable for that portion of the loss assessment that is reapportioned as a result of the granting of final (full or pro rata) exemptions.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective market shares as adjusted pursuant to (c)1ii above.

i. Members that have been granted a deferral shall remain liable to the IHC Program for the amount deferred and any additional amounts required by N.J.A.C. 11:20-11.6.

ii. Upon eventual payment of the deferred amount to the IHC Program, the members to whom the deferred amounts were reapportioned will be credited for those amounts previously apportioned to them.

3. Assessment amounts for members granted a final (full or pro rata) exemption by the Board shall be redistributed to the other members not receiving a final (full or pro rata) exemption. The distribution shall be based on an adjusted market share of the members not receiving a final (full or pro rata) exemption. This adjusted market share shall be the ratio of the member's net earned premium to the net earned premium of all members not receiving a final (full or pro rata) exemption for the preceding two-year calculation period. This additional redistributed portion of the assessment shall be determined by multiplying the total amount of redistributed reimbursable losses from those carriers receiving a final (full or pro rata) exemption for the preceding two-year calculation period by the carrier's market share as adjusted by this paragraph.

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period unless the member has been granted a full exemption from assessments for the preceding two-year calculation period by the Board in accordance with N.J.A.C. 11:20-9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about May 1 of the year following every two-year calculation period, of the total reimbursable net paid losses for the preceding two-year calculation period and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period.

2. On or about September 1 of the year following every two-year calculation period, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding two-year calculation period.

3. The IHC Program Board may, as necessary, make reconciliations from the preliminary notice of the assessment for reimbursable net paid losses which may include adjustments in market share and adjustments for deferrals granted.

4. Upon the resolution of all outstanding matters including audits of reimbursable losses and appeals filed pursuant thereto, the IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the appropriate two-year calculation period by invoice stating the dollar amount then due or credit, if any, against future assessments. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

(e) Assessments amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20-11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the two-year calculation period. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request,

may be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Upon receipt of notice that amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board and provide notice to the carrier of the principal amount and interest amount. The calculated amount shall be returned to the member with interest within 30 days from the date the interest has been calculated.

New Rule, R.1994 d.165, effective March 1, 1994.

See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

The Expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.

See: 37 N.J.R. 2884(a).

Case Notes

Regulation exempting health insurance carriers that met only 50% of their individual health insurance policy goals from any second-tier assessment for failing to issue minimum number of individual policies, while requiring certain carriers meeting 49% and less of their goals to meet entire cost of providing coverage, violated requirement of Individual Health Insurance Reform Act that there be an equitable sharing of Individual Health Coverage Program (IHCP) losses among all carriers. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Individual Health Insurance Reform Act did not authorize Individual Health Coverage Program (IHCP) regulation that completely excused carriers from second-tier assessment if they received pro rata first-tier exemptions from assessment for failing to meet Act's enrollment requirements; Act did not allow New Jersey Individual Health Coverage Program Board of Directors to further penalize carriers who were not entitled to any exemption. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than \$20.00, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

New Rule, R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) The standard individual health benefits plan established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A;
2. Plan B, "Individual Health Benefits Plan," Exhibit B;
3. Plan C, "Individual Health Benefits Plan C," Exhibit C;
4. Plan D, "Individual Health Benefits Plan D," Exhibit D;
5. Plan E, "Individual Health Benefits Plan E," Exhibit E;
6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and
7. Plan A/50, "Basic Health Benefits Plan A/50," Exhibit U.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C and D as set forth in Exhibits U, and B through D, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plan D shall offer the following annual deductible options to the policyholder for each plan:
 - i. \$500.00 per individual and \$1,000 per family unit;
 - ii. \$1,000 per individual and \$2,000 per family unit;
2. Members offering Plans A/50, B and C shall offer the following annual deductible options to the policyholder for each plan:
 - i. \$1,000 per individual and \$2,000 per family unit; and
 - ii. \$2,500 per individual and \$5,000 per family unit.
3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:
 - i. \$1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in

which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit;

ii. \$2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit.

iii. In the case of single coverage, the greater of: \$1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: \$2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered family;

iv. In the case of single coverage, \$2,000, and in the case of other than single coverage, \$4,000;

v. In the case of single coverage, \$2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted, per covered person; and in the case of other than single coverage, \$5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted.

vi. In the case of single coverage, \$5,000, and in the case of other than single coverage, \$10,000;

4. Members offering Plan/A50 may offer the following annual deductible options to the policyholder for each plan:

- i. \$5,000 per individual and \$10,000 per family unit; and
- ii. \$10,000 per individual and \$20,000 per family unit.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: \$150.00 hospital inpatient copay, \$150.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 separate emergency room copay, \$25.00 maternity copay, and \$15.00 for all other copays. All HMO members choosing to offer optional health benefits plans may offer one

or both of the following copayment options, provided that all options marketed shall be offered to each applicant;

1. \$250.00 hospital inpatient copay, \$200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$20.00 for all other copays; and/or

2. \$100.00 hospital inpatient copay, \$100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$10.00 for all other copays.

3. \$300.00 hospital patient copay, \$300.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$30.00 for all other copays.

(d) Each of the standard health benefits plans, except Plan A/50 and the deductible options listed in (b)3 above, may be offered through or in conjunction with a managed care network, and the standard plans may be offered as a PPO or POS plan by a carrier that is exempt from the requirements of P.L. 1993, c.162, § 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute. These plans should be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6;

2. The coinsured charge limit specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits B through D in the Appendix, shall be the maximum amount of covered charges a covered person must incur for the in-network and out-network benefits combined before benefits are paid by the carrier at 100 percent;

3. The HMO Plan copayment levels of \$10.00, \$15.00, \$20.00 and \$30.00 may be substituted for deductibles applicable to one or more of the in-network benefits; and

4. The out-network benefit level shall be the coinsurance level of the standard plan. Plan B offered through or in conjunction with a managed care network shall have an out-network coinsurance amount of 60 percent, Plan C shall have an out-network level of 70 percent, and Plan D shall have an out-network level of 80 percent.

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for medical services, based on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or such other state where services or supplies are

EXHIBIT P

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative
January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT Q

(RESERVED)

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Administrative Change.

See: 27 N.J.R. 1423(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

Repealed by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Certification of Compliance with New Jersey Individual Health Benefits Plans".

EXHIBIT T

(RESERVED)

New Rule, R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative
November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.131, effective March 25, 1999.

See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Explanation of Brackets for Individual Health Coverage
Standard Plans and Application".